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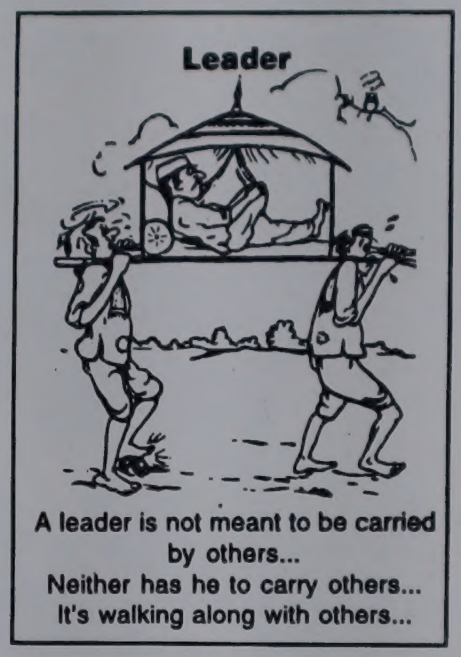
Role of Private Sector in Health Care

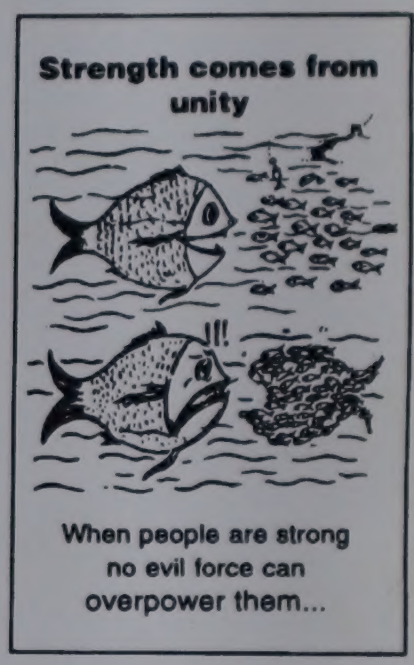
BOOK

Cartoons For Discussion on Communication

One-way communication creates a great deal of confusion between the sender and the receiver...



A leader is not meant to be carried by others...
Neither has he to carry others...
It's walking along with others...



When people are strong no evil force can overpower them...

... Knowingly or unknowingly, we at times fall into the trap of miscommunication, non-communication, self - centred communication etc. due to lack of clarity over the vision and various concepts that guide us in achieving the objectives in our work. And, at times, we look forward to solutions outside of ourselves not knowing that we are part of the problems.

... The attempt is aimed at promoting better communication and relationship with people as well as among the team members involved in health action. The book is priced at Rs. 20/- and postage extra.

You can use these cartoons

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- **To improve communication skills, and**
- **As an effective teaching aid which you can blow up into posters too!**

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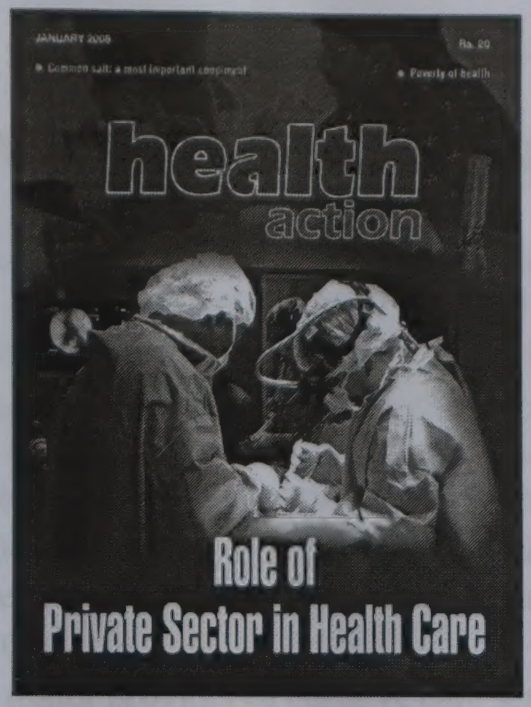

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Thought for the Month

"Out of clutter, find simplicity. From discord, find harmony. In the middle of difficulty lies opportunity."

Albert Einstein

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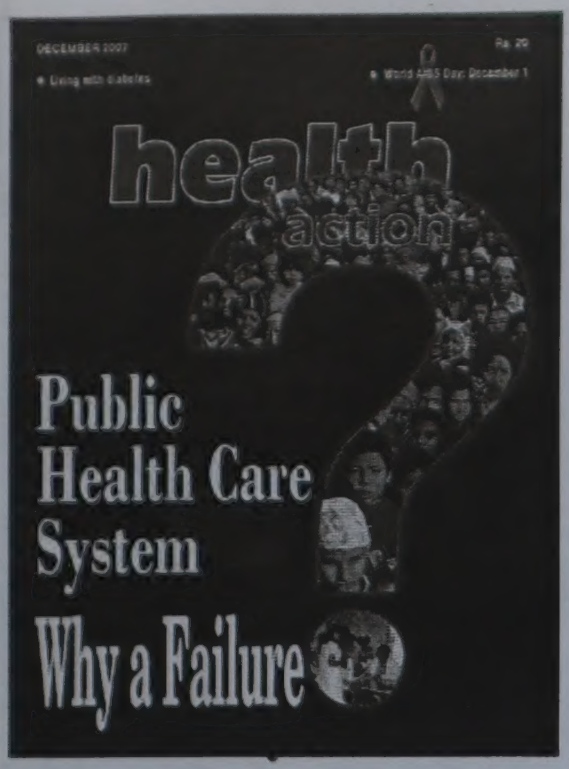


Causes of public health failure well analysed

The article entitled: "Strengthening Public Health Capacity: challenges, opportunities and threats", (December 2007 issue) by the community health visionaries Dr Ravi Narayan and Dr Thelma Narayan, once again confirms their challenging role and it is also a demanding call to each one of us. "The situation of public health and health systems is so bleak that we need actions on all fronts with a strong 'new public health community health movement' that can support 'demand creation' with a rights-based perspective among the disempowered ... "

If each one of us doctors takes this sincerely and commit ourselves to this cause, then surely India will shine! The causes of failure of public health in India are also analysed well by the other contributors.

Dr S R Conard Mary,
Uvari, Tamil Nadu

A truly valuable magazine

We now read *Health Action* with greater interest than before. It is a truly valuable magazine that provides us with lots of useful information!

Baby Mathews
New Delhi

Editorials have always impressed me

I read all articles of all issues of *Health Action.* The editorials have always impressed me which are really standard ones. Sometimes I circulate editorials among my friends.

Prakash C Padhan
LEPRA-Orissa

Forthcoming themes — 2008

(The order is subject to change)

- Fighting HIV/AIDS through Community Health
- Strike by Health Professionals
- Community Health Insurance
- Right to Information
- Homeopathy
- Impact of Information Technology on Health
- Review of NRHM
- Diabetes
- Urban Health Mission
- Adolescence and Health
- Innovative Interventions like 108, 104 and Arogyasree
- Private Public Partnerships (PPPs)

Public-private mix: prescription for improved health care

Health care has become commodified and the private sector is the dominant provider of health care globally as well as in India. New medical technology has aided such a development and the character of health care as a service is being eroded rapidly.

Government hospitals and health centres existing across the length and breadth of the country have failed to provide basic health care to people. The public health system failed through improper planning, inadequate financing and poor organization.

Today, with an estimated 700,000 qualified practitioners of various systems of medicine, and an equal number of unqualified practitioners in individual private practice, we have the largest private health sector in the world.

Private sector is already the major provider of curative care services in India. National Health Account shows that 77% of total health expenditure takes place in the private health sector. As the public sector is ill-equipped in all respects, people seek care from private sector.

The private sector which accounts for 70% of the hospitals in the country, provides about 60% of all out-patient care and as much as 40% of in-patient care. By 2010, it is expected to notch up to 80% of the health care market, comprising hospitals and diagnostic centres. By 2010, an additional 4.5 lakh hospital beds will be required. Today, the value of the health care sector is over $ 34 billion, translating to roughly 6% of GDP and the sector is projected to grow nearly $ 40 billion by 2012, according to a study. The competition emerging among private health care institutions is a blessing in disguise -- it leads to the formation of many state-of-the art-treatment facilities, though they benefit only a few, the rich or those under a security scheme.

But the sector raises various concerns, lack of regulation being the main one. Private medical practice has now existed too long without any control and regulation. For a couple of decades or so, increasing pressure is being exerted on the private health sector to put its house in order. There is a need to bring in an entirely new range of comprehensive regulation as existing in countries which have near-universal health care provision with predominantly privately-managed care. But while making regulatory measures, pro-profit and non-profit health care institutions should not be treated alike. Non-profit organizations should be guided by a separate set of regulations. So also, rural and urban institutions should be treated differently. Another concern is that of equity; only those who can pay have access to crucial services. This means drastic changes in health policy and reorganization of the entire health care system. We need to recognize that privately provided health care has come to stay but we also need to believe that it needs to be organized in an appropriate manner helping to evolve a public-private mix which would provide affordable health care to all. Private-public partnership in health care would enable the government to collaborate with the private sector in improving the outcome of health investment which would pave the way for universal access to health care.

This issue deals comprehensively with the theme. T R Dilip, Denny John, Chandrima Chatterjee, Ravi Duggal, Rama V Baru are the cover story section contributors.

Wishing a happy and healthy New Year to all *Health Action* readers!

Rev Dr Sebastian Ousepparampil
Managing Editor

COVER STORY

Role of private health sector in India

T.R. Dilip

Private sector is already the major provider of curative care services in India. About 80 percent of the ailments requiring outpatient treatment, and 60 percent of ailments involving hospitalization are treated in the private health care sector. Consequently, the official National Health Accounts shows that 77 percent of total health expenditure in India takes place in the private health care sector. Recent trends indicate that though the Central government has augmented its health care spending in recent years, the state governments are unable to replicate the same due to fiscal crises. Therefore, public spending on health is likely to remain the same or even plunge further, leading to an overwhelming dominance of private health care sector in future.

As compared to curative care services, the private sector participation is very low in the provisioning of preventive and promotive care services. These services include public health programmes relating to Tuberculosis, Malaria, HIV/AIDS, immunization activities and maternity-related care. Incidentally, these are public health and maternal child health issues, where poorer sections and under-developed regions lag behind richer sections and developed regions respectively. Hence there is an intrinsic polarization in the national health system with the private sector focusing on curative care services and public sector covering preventive care services and also in areas where outreach of private sector is limited.

Now the issue is: Why are majority of the patients seeking care from the private health care sector? As is known, the public health care system is characterized by shortage of trained workforce, infrastructure and supplies. Due to this, out-of-pocket expenditure incurred by a patient seeking care from a government institution is increasing. As a result, the gap in out-of-pocket expenditure between public and private sector has come down, especially in the case of outpatient care services. Hence the ailing person/household has to choose between a user-charge-driven private sector and a public sector where one has to spend from one's pocket for most of the services, excluding consultation. In this regard, it is obvious that majority are seeking out-patient care from the private sector, which, in addition, offers flexible timings than the latter. Such an overwhelming use of private facilities is not seen for inpatient care, where the huge out-of-spending often turns out to be catastrophic in nature for the ailing person's

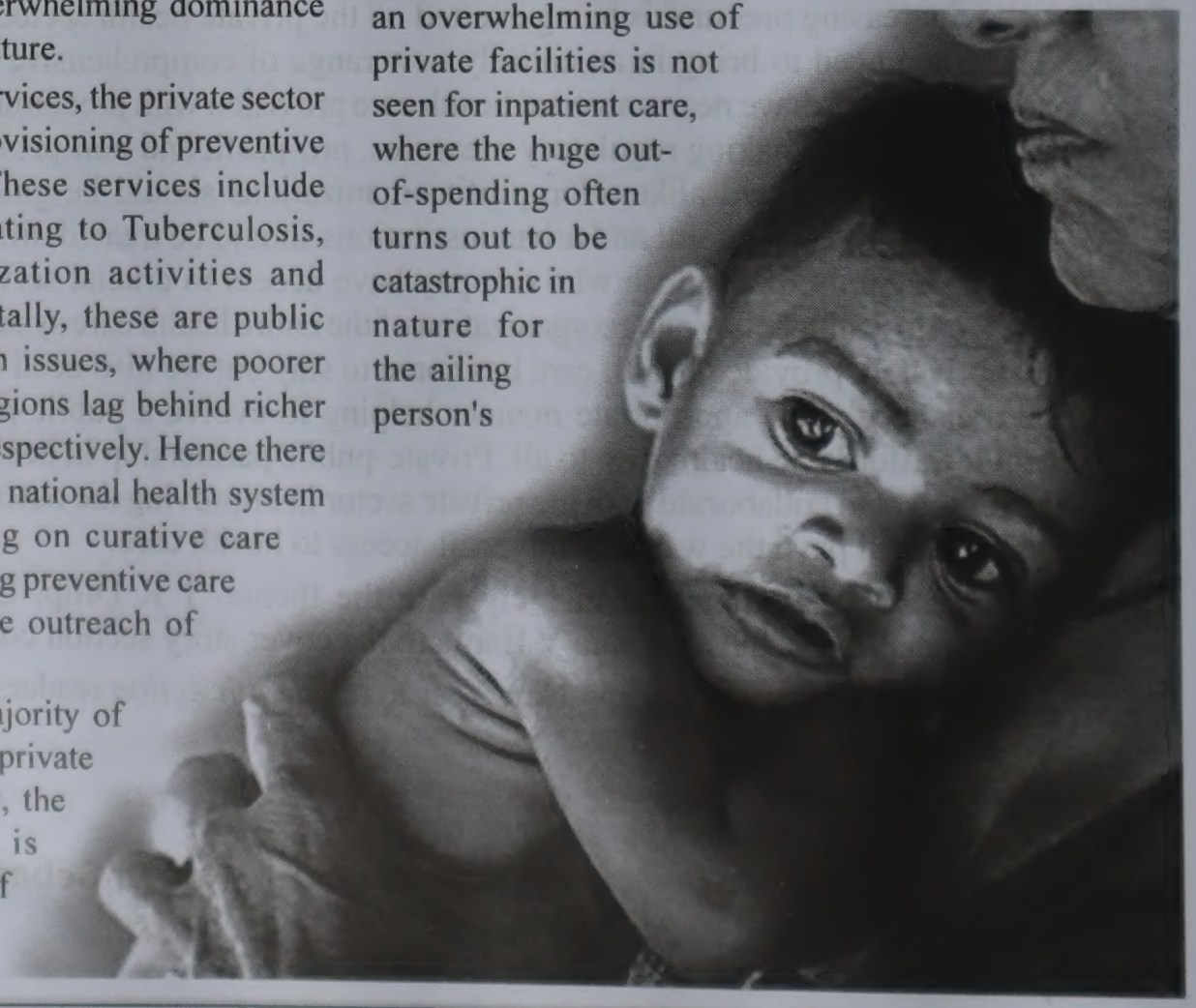


Chart 1: Percentage utilizing In-patient treatment from private sector, India 1986-2004

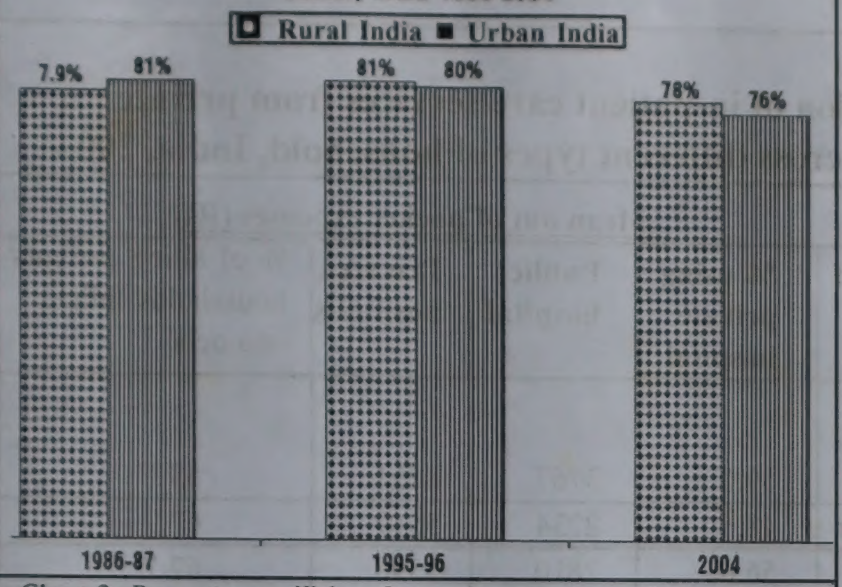
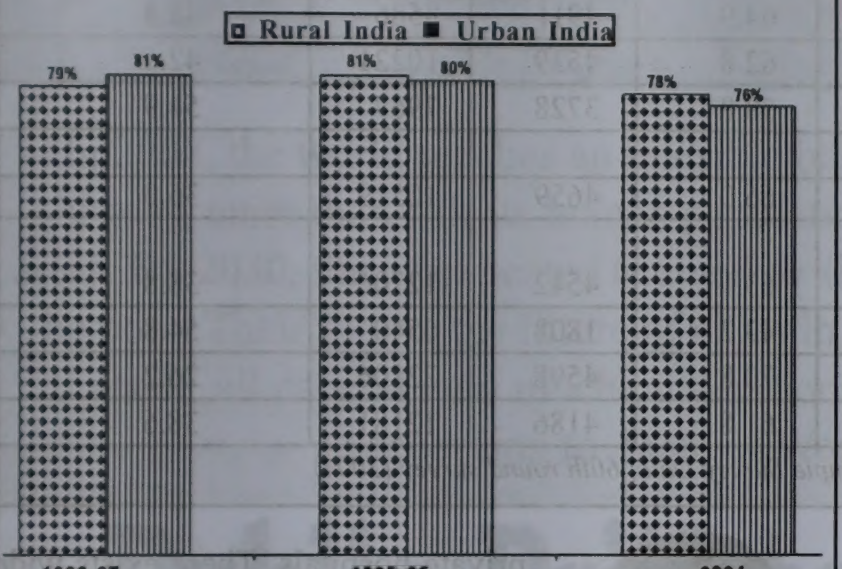


Chart 2: Percentage utilizing Out-patient treatment from private sector, India 1986-2004



household. But private sector has slowly emerged as a major provider of in-patient care since 1990s.

The public sector has always been instrumental in creating a market for the private health care sector. In the beginning, it was through making the socially and economically backward population closer to modern medicine. The same is operating today in the case of immunization, family planning and delivery care where government intervention has created a voluntary demand for private facilities. Private health care sector seems to be cashing in on this newly created demand and will certainly play a larger role in the provisioning of these services in the coming years.

However, one major concern raised against the expansion of private health care is its unregulated nature with a large potential for profit-motivated medical malpractices. As we are aware, there is a huge number of non-qualified medical practitioners surviving out-patient care market. There are studies which clearly show that as compared to government institutions, the risk of having a caesarian section is higher if delivery is taking place in a private hospital. Similarly, there are evidences supporting that prescription of unnecessary drugs and diagnostics is higher if treated in a private sector than in a public sector. Though these allegations cannot be generalized, the government should make registration and accreditation of private medical institutions mandatory. Benefits from such a cost-effective intervention are innumerable due to its potential in minimizing the present public health crisis arising out of unregulated providers in the health care market.

With increasing number of private medical institutions, a kind of competition is emerging between private health care institutions. This has come out as a blessing in disguise for the health system, with various hospitals establishing state-of-the-art facilities and trying to set standards in the provisioning of quality health care. But the role of this type of establishment is limited as the patient needs to be extremely rich or has to be under the cover of some health security scheme in order to avail services from such specialized institutions.

Health insurance sector is becoming visible in India and the private providers appear to be benefiting from this scenario. A family with health insurance coverage is most likely to prefer a private hospital over a public hospital. Therefore, the role of private sector will improve further with the ongoing rapid improvements in the coverage of health insurance schemes. Here again, only medium and larger private hospitals will only benefit over small hospitals or nursing homes because insurance providers insist on treatment from large hospitals. Private hospitals with a capacity below 15 beds are even excluded from the Universal Health Insurance Schemes.

Health insurance sector is becoming visible in India and the private providers appear to be benefiting from this scenario. A family with health insurance coverage is most likely to prefer a private hospital over a public hospital. Therefore, the role of private sector will improve further with the ongoing rapid improvements in the coverage of health insurance schemes.

Though the private health care sector has expanded, access to treatment from private health sector is not uniform. A simple example of this is the class differentials in access to in-patient care services *(see Table)*. It's

evident that utilization of in-patient care services from private hospitals is common among all types of households in both rural and urban areas. In rural areas, the private sector preference is highest among 'self-employed in agriculture' subgroups and lowest among households where a major part of income is from 'agricultural labour'. In urban areas, the households whose major part of the income is from 'casual labour' has the lowest level of access to private hospitals. Again, these subgroups with the lowest level of utilization of private hospitals also spend lesser if they are seeking care from a public/ private hospital. Despite that, the proportion of households falling into debt out of total households where at least one member has been hospitalized in the last one year, is very high among the relatively poorer subgroups. Here 'debt' indicates that household has resorted to borrowing or to sale of assets for financing in-patient care treatment. In a nutshell, the Table demonstrates the nature of variations in overall access to health care and differentials in the capacity to pay for health care across rural and urban India.

Table

Utilization of in-patient care services from private hospitals across different types of household, India, 2004

		Mean out of pocket expenses (Rs)		
Type of household by income	**% using private hospital**	**Public hospital**	**Private hospitals**	% of ailing patients' households falling into debt
Rural India				
Self-employed in non-agriculture	59.0	3767	8254	53.1
Agricultural labour	48.6	2234	5549	67.9
other labour	56.0	2810	5590	62.7
Self-employed in agriculture	64.9	4911	8586	48.4
Others	62.8	4539	10221	42.6
Rural- Total	58.8	3728	7967	54.9
Urban				
Self-employed	66.0	4659	10519	36.0
Regular wage/ salary earnings	63.1	4542	12706	38.8
Casual Labour	43.2	1808	6540	54.8
Others	70.8	4598	22106	26.2
Urban- Total	61.8	4186	12181	38.6

Source: National Sample Survey Data, 60th round survey (2004).

As is known, treatment from a private hospital is more expensive, but one can note that the out-of-pocket expenditure incurred is clearly a function of their economic background. The richer sections are spending more irrespective of whether treatment is sought from the public or private sector. The fact that there is a difference in the disease-pattern and that they may be using paywards or special wards is well understood. However, that alone could not explain the huge differentials in out-of-pocket expenditure between rich and the poor seeking care from private hospitals. There exists wide variations in the pricing of services within and across private hospitals. This indirectly hints that private hospitals accessed by the poor characterized by lower capacity to pay may not be the same as the one accessed by the richer sections. This will be operating in the out-patient market too, with a larger share among low socio-economic groups depending on non-qualified private practi-tioners than their counterparts from better socio-economic groups. Such a divide within the rapidly expanding private health care system is an unhealthy trend which is likely to create further imbalances in equitable access to health care across the county. ■

The author is Lecturer, Centre for Development Studies, Prasanth Nagar Road, Ulloor, Thiruvananthapuram-695011 Kerala, Email: dilip@cds.ac.in

COVER STORY

In 2008, the world reaches an invisible but momentous milestone: For the first time in history, more than half its human population, 3.3 billion people, will be living in urban areas. By 2030, this is expected to swell to almost 5 billion. Many of the new urbanites will be poor. Their future, the future of cities in developing countries, the future of humanity itself, all depend very much on decisions made now in preparation for this growth according to State of World Population 2007, UFPA.

Public-Private Partnerships a way to strengthen urban health services

Denny John

Population growth in India follows the 2-3-4-5 syndrome, 2% rise in total population, 3% rise in urban population, 4% rise in mega-city population, and 5% increase in urban slum population (Chatterjee, 2002). Out of India's total population of 1027 million, 285 million (27.8%) live in urban areas (as per Census 2001) and around 21 percent of this urban population live in slums (National Commission of Population, 2000, Ministry of Health and Family Welfare, GOI). But, this does not represent the true picture as the slums will also include squatter populations, migrant colonies, people living on pavements, construction sites etc, which are usually left "invisible" when considered by municipal authorities and city planners. We are well aware that the harsh environments in which most people in the slums live expose them to a number of health and sanitary problems, putting them in much higher morbidity and mortality when compared to non-slum populations. Research studies have shown that the health indices of urban slum dwellers are worse than that of the rural population (MOHFW 2002), even though the health infrastructure is believed to be better in urban areas than rural areas. This high growth in urban population, especially in the slums with no corresponding increase in the number and access of public healthcare facilities, has resulted in increased access to private healthcare facilities.

Indicator		Urban	Rural
% distribution of outpatient treatments by source of treatment	Govt Sources	19	22
	Private Sources	81	78
% distribution of hospitalized treatments by type of hospital	Govt Hospital	38	42
	Private Hospital	62	58
Average total expenditure(Rs) for outpatient treatment per person (Medical expenditure)	Govt Sources	7	11
	Private Sources	299	246
	Other Expenses	20	27
Average total expenditure(Rs) for inpatient treatment per person (Medical expenditure)	Govt Sources	3877	3238
	Private Sources	11553	7408
	Other Expenses	516	530
% share of institutional deliveries by source of treatment	Govt Hospital	31	18
	Private Hospital	69	72
Average expenditure (Rs) per childbirth by place of delivery	Govt Hospital	994	1165
	Private Hospital	5480	4137
	Home	552	414

The NSSO 60th round reveals:

A District-based Facility Survey done by National Commission on Macroeconomics and Health (NCMH) in 8 districts (Financing & Delivery of Health Care Services in India, NCMH Report, MOHFW, 2005) revealed that of the total 9457 facilities in these areas, 61% were run by private qualified providers and the ratio of the public-private sector is 60:40 in rural areas as compared to 10:90 in urban areas.

This clearly points to the fact that despite better physical access to care and availability of public health services, the increased dependency on private health facilities than on public health facilities by urban populations when compared to rural populations has resulted in higher average cost for accessing health services and loss of household income. This means that there is an emergent need for expansion of public health services even in urban areas so as to reduce the financial burden on the urban poor.

Private-public partnership (PPP) is a new and essential strategy to extend the scope of the existing public health system in the nationwide perspective. Report on National Planning Workshop on Public Private Partnerships in the Health Sector in India, 2005, states that implementing this strategy does not mean that the government would abnegate or forfeit its responsibilities, rather it would mean that the government in collaboration with the private sector intends to provide the necessary financial and managerial resources for the health sector in order to improve the outcome of health investment.

The urban populations, especially those living in the slums, are affected due to the following factors:

- Lack of Government Priorities in Urban Health
  Although urban health has been mentioned in the 1st Five-Year Plan (FYP), health programmes implemented by the Central Government have been mainly rural-centered. Till the 9th Five-Year Plan, the Government of India, with more emphasis on rural health, had been neglecting the aspects related to urban health. However, Government of India has now identified urban health as a priority area under the 10th FYP (Planning Commission, 2002), National Population Policy (National Commission on Population, 2000), Reproductive and Child Health-Phase II, and the National Health Policy, 2002 (MOHFW, 2002).
- Inadequate Public Health Infrastructure
  There is the presence of three-tier health delivery structure in rural areas which is lacking in the urban areas resulting in poor coverage and low utilization of public health facilities in the urban areas. There is only 1 Urban Primary Health Centre (often with only 3-4 ANMs) for about 1.5 lakh urban population resulting in low utilization of public health services in urban slums (Gujarat State-wide Multi-indicator Cluster Surveys (MICSs), 1996). Studies in Mumbai indicate that 32 percent of the reported ailments remain untreated (Duggal, Nandraj & Vadiar, 2000); and that the public sector provides treatment to only 20 percent of the population (CORT, 2000; IIPS & ORC Macro, 2000).
- Varying socio-economic, environmental and infrastructural conditions

There exist disparities in infant and child mortality rates, malnutrition, and incidence of diarrhoea across different slums due to differing socio-economic, environmental and infrastructural conditions. Below is the baseline survey results of the Slums of Indore:

Nutrition status, health behaviour and services	Highly vulnerable availed	Moderately vulnerable slums	Other slums (less vulnerable) slums
Percentage of deliveries at home	69.2	50.2	38.3
Percentage of children completely immunized by 12 months among children of 12-23 months	33.8	45.3	48.8
Percentage of children under 2 years — under-weight for age-below-3SD	19.9	15	11.9
Current use of family planning method (any method, currently married women)	43.6	44.8	48.3

Source: Environment Health Project-India. Baseline Child Health Survey in Urban Health in Indore, New Delhi: Environment Health Project, 2004

- Increased penetration of private healthcare facilities

  Three-quarters of human resources and advanced medical technology, 68% of a total of over 15,097 hospitals and 37% of over 623,819 beds in the country are in the private sector (Directory of Health Services, GOI 1996). Government policies such as National Health Policy, 1983, and initiatives from the Ministry of Finance, Government of India, have advocated the provision of health services through the private sector through a slew of subsidies such as capital investment exemptions such as land, bank credit, import duty etc. But, in the absence of government regulations and standards for private health care facilities, they are often associated with poor quality and higher costs.

- Lack of social health security mechanisms

  Only about 10 % of the total population is covered by any health security mechanisms (Ellis, Alam & Gupta, 2000). This lack of coverage of social health security has resulted in high out-of-pocket health expenditures (around 98.4 % of total health expenditure) in the country (National Health Accounts, 2001-02). Financial reasons have been cited by around 6-8 percent of patients who fell ill but did not seek care (NSSO 60th round). Utilization of medical care has also resulted in increase in poverty levels due to hospitalization expenses (World Bank, 2001) and impoverishment (van Doorslaer P et al, 2006) and is one of the three main causes of impoverishment in the country (Krishna A, 2004).

Provision of assured and credible primary health services of acceptable quality in urban areas is an emerging priority for the government (Presentation, International Conference of Urban Health Initiatives, TV Raman, Director (Area Projects), MOHFW, 9 Feb 2005). The decreasing trends of public health spending in terms of share of government's budget (from 1.2 % of GDP in 1986 to 0.9% in 2001) and proportion of Gross Domestic Product (from 3.5% of government's budget in 1986 to 2.7% in 2001) can be attributed to the decline of public health services in the same period (Duggal, 1997). As per a government source (Presentation paper, GOI Policies on PPP Initiatives in Health and Family Sector, National Planning Workshop on Public Private Partnerships in the Health Sector in India, Dr Tarum Seem, Dy Secretary, MOHFW, GOI, 2005) according to population norms, 158792 sub-centers, 26022 PHCs and 6496 CHCs are required in order to tide over the shortage of infrastructure and an additional requirement of 880 doctors at PHC, 11191 ANMs, 18989 pharmacists etc are needed to tide over staff shortages of medical and paramedical staff.

Public-private-partnership(PPP)

PPP can be defined as a collaborative programme for synergizing the efforts of the private sector to provide comprehensive health care facilities. Currently, certain models of PPP like franchising, branded clinics, contracting in and contracting out, social marketing, involvement of the corporate sector, partnering with CBOs/NGOs, mobile health vans, and health insurance exist in the country.

PPP initiatives for the urban poor

There are a number of initiatives in the country with regard to PPP initiatives for urban health services. These include covering a wide range of services for contracting the management of the Urban Health Centres to NGOs, contracting in private practitioners/specialists for public sector facilities, providing outreach services, contracting delivery of health services in unserved areas to NGOs, social franchising/social marketing, community health insurance/health vouchers, partnership with corporate sector and formation of community-based organizations

under the MNGO/SNGO scheme.

Case-studies of Public-Private Partnership (PPP) initiatives for the urban poor – very good

- Arpana Swasthya Kendra (ASK), New Delhi.
  Under the partnership between the Municipal Corporation of Delhi (MCD) and Arpana Trust (AT), there is a provision of comprehensive health services to the urban poor in Delhi's Molarbund resettlement colony. The partnership with MCD has enabled Arpana to run a health centre, primarily for women and children, in Molarbund with the building, equipment and medicines provided by MCD. The Arpana Trust is responsible for providing health services through its health centre 'Arpana Swasthya Kendra' (ASK). As partners, Arpana Trust and MCD has fixed responsibilities and provide a share of resources as agreed to in the partnership contract. With 25000 patients annually and around 100-120 patients daily, ASK has 23 volunteer doctors with weekly clinics in specialities such as cardiology, ophthalmology, radiology, gynaecology, pediatrics and community medicine; a mobile van provides maternal and child services to another 11000 people .

Measured against its objectives, the MCD-AT partnership has impressive achievements: 84% of pregnant women attend antenatal clinics, 85% of them receive complete immunization, and 90% children receive complete immunization coverage. The nutrition workshops and education inputs inform participants about various food groups, nutrients, diseases caused by deficiency of these nutrients, nutritious recipes etc. The undernourished are weighed, given hemoglobin tests, motivated and given daily milk and supplements.

The user-fees levied by ASK for its services (list provided below) are similar to what the poor would need to pay in AIIMS hospital, but the saving of transport costs and quality of services provided by ASK doctors outweigh the advantages than the disadvantages.

Services	Charges (in Rs)
OPD Visit (Initial) inclusive of OPD card and 3-days' medicines	10.00
OPD Visit (Follow-up)	5.00 (only for medicines)
ANC/PNC Visits + lab tests	Free
Ambulance Services	50.00 (one way for institutional deliveries at Safdarjung Hospital) 100.00 (other patients)

Indicators (percentages)	Baseline survey (Jan 2000)	Evaluation (June 2002)
Pregnant women visited by health personnel	10	95
Antenatal cases registered before 16 weeks	46	65
Institutional deliveries	26	80
New-borns weighed immediately after birth	42	75
Low-birth babies	8	7
Children fully immunized	31	85

- Urban Slum Health Care Project, Andhra Pradesh.
  Under the Andhra Pradesh Urban Slum Health Care Project (an extension of IPP-8 and linked with RCH-II), the government contracts with select non-governmental organizations (NGOs) to manage health centres in slums. The NGOs are selected through a process of putting up advertisements for partnership, receiving applications and selection through a District-level Committee chaired by the District Collector. To serve three million people, the project established 192 Urban Health Centres in 74 municipalities of 21 districts. Each covers approximately 15000-25000 slum dwellers; the standard Urban Health Centre has a medical officer, two female multi-purpose health assistants, a community organizer, three assistants and a project coordinator. The scheme works through community mobilization of 'Mahila Aarogya Sanghams' (Women's Well-Being Associations), self-help groups and workers in ICDS department. The major components are service delivery, community mobilization and communication for behaviour change.

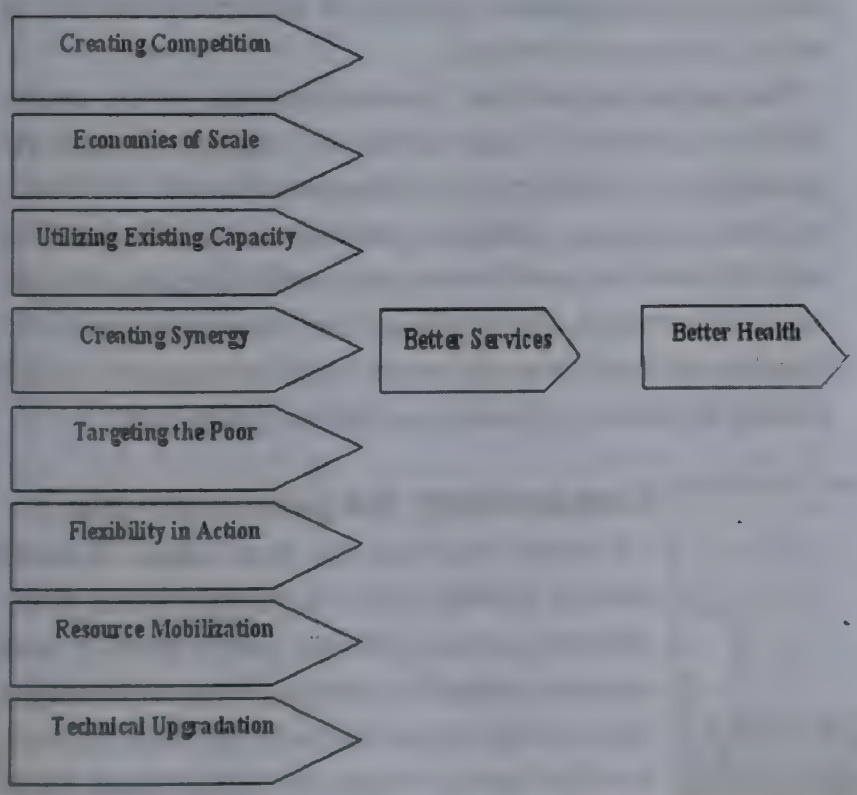
The progress achieved in the project was evident in an evaluation survey conducted by TNS Mode Pvt. Ltd in 2002.*(see Table above)*

- Indore Urban Health Programme
  USAID-EHP (India) is supporting the implementation of an urban child health programme in 75 slums of Indore through five Non-governmental Organizations – Community Based Organizations (NGO-CBO) consortia, since April 2003. The five NGOs are Bal Niketan Sangh (BNS), Pushpkunj Family Helper Project Trust (PFHPT), Bhartiya Grameen Mahila Sangh (BGMS), Centre for Development Economics and Development Consultants Society (CECOEDECON) and Indore Diocese Social Services

Society (IDSSS). These NGOs have been implementing the programme in collaboration with nine Lead CBOs (LCBOs) and 87 Basti CBOs (BCBOs). A public sector-driven approach, focusing on supply/ service improvement- "Ward Coordination Model" is also being promoted by EHP. The main objectives of the programme are: (a) to increase coverage of services and adoption of key health behaviours in neo-natal survival, diarrhea control and other child health priorities; (b) to improve capacities of CBOs, NGOs, private and public sector health providers in health behaviour promotion, to use child health data and for building partnerships; (c) to ensure better targeted policies and increased allocation of resources for urban slum health; and (d) to develop replicable models for urban child health programmes.

The progress made in timely immunization (DPT I) could

Month	% DPT I Timely public health
October	28
November	30
December	100
January	100



be visualized by the following table for the year 2004-05:

(Adapted from Workshop Report, National Planning Workshop on Private Public Partnerships in the Health Sector in India, 28-30 November, 2005)

The benefits of PPP can be summarized as below:

Various government policies and task-force recommendations have prioritized PPP initiatives in urban populations, which include National Slum Policy, 2005, Reproductive and Child Health-Phase II; Jawaharlal Nehru Urban Renewal Mission, 2005; Strategies for Urban Health Care, Task Force Report on NRHM, 2006; Guidelines for Development of City-level Urban Slum Health Projects, 2004; and Task Force Recommendations for the XIth Five-Year Plan.

But, there exists certain challenges for PPP in urban healthcare, which include;

- Limited acceptance of PPP approach among public and private counterparts.
- No effective mechanism for identifying the right NGOs
- Lack of experience in developing and administering partnership instruments (MOUs and Agreements).

There is also a need for certain mechanisms to ensure a smooth and successful partnership such as;

- Streamlining of operational aspects of partnership and fund release modalities.
- Building mutual trust through operational partnership agreement would sustain public private partnerships.
- Capacity-building of NGOs should be based on quality service delivery while the government should focus on the management aspects of PPPs.
- Payment should be service-or-performance-based.

Initiating Public Private Partnerships in Health-Vital Components (STRAIGHT):

- Identifying the **SCOPE** of partnership
- Identifying the appropriate **TARGET POPULATION**
- Selecting the **RIGHT PARTNERS** and the **RIGHT MODEL OF PPP**
- Ensuring **ACCOUNTABILITY** of private providers
- Ensure active **INVOLVEMENT** of the government
- **GENERATE SUPPORT** of all the key stakeholders through IEC, advocacy and rapport building
- **HIGHLIGHT ACHIEVEMENTS** of the partnerships
- Build **TRUST** of all the partners and clients

Experience has shown that maintaining the private partners' managerial autonomy improves the outcome.

(Adapted from Workshop Report, National Planning Workshop on Private Public Partnerships in the Health Sector in India, 28-30 November, 2005)

"As per Dr Siddharath Agarwal, Country Representative, Urban Health Resource Centre (UHRC), New Delhi, Public-Private Partnerships (PPPs) for urban health can be an important strategy for meeting the critical public health challenge of quickly expanding services and reach the urban under-served." ■

(The author is a physical therapist and healthcare management professional. Currently, Faculty, Institute of Public Health, Bangalore. He is working on issues of community health, healthcare management, and health financing in urban areas of Maharashtra State. His previous assignments included management of rural mission and urban not-for-profit hospitals; and disability programmes in a few northern states)

Private Participation in Health Care

Chandrima Chatterjee, Ph.D

A large number of health transactions in both low and middle-income countries take place outside the publicly-provided health care delivery system making it difficult to ignore the private sector for purposes of planning and financing of the health sector. In fact, in many countries the public system is now a minority provider of services. In India, for example, estimates for household private health care expenditure range up to 80 per cent. Responses to the presence of the private interests in the social sector have ranged from positive enthusiasm for its potential to increase efficiency and quality in service delivery through competitiveness to strong objections raised on its role in creating barriers to access and equity. Both the responses are right and wrong in their own terms. What cannot be missed perhaps in this whole debate is the role of the government in a pluralistic environment of health service provisions where an increasing number of health care transactions take place outside the organized health care economy. A much broader justification for public intervention in health activities has come to be accepted for reasons of enhancement of equity in access and other social objectives. But there are always questions on the appropriate mechanisms for government interventions to control the unregulated domain of multiple providers of health goods and services.

This paper argues that private interests in the health sector existed in India prior to Independence; its phenomenal growth post-independence can be attributed to global changes, domestic policies and strategies. But with the private sector emerging as the largest provider of health services, the challenge for the government is to develop effective ways to control the unorganized health market to ensure universal access to health care.

Demarcating the public/private ?

Private practice by individual doctors existed in India prior to Independence. Post-independence, private participation was accommodated in various forms and with the expanding opportunities for the capital-seeking new avenues for investment, there was a growth of the private provisioning of services which included the pharmaceutical and medical equipment industry, public and private schemes for financing and institutions for the delivery of medical care. It is significant to note that privatization of the medical care in India took place in the background of changes in the public sector.

Private interests in health care were promoted through the successive policies even though the State played an important role in provision and administration in key areas like education, health and other social services. The intermittent reference to the presence and participation of the private sector in the health policies and plan documents was just a legitimization of the already large presence of the existing private sector in health care. This type of growth has attributed a peculiar character to the privatization of the medical care where private health sector has grown substantially without any definitive guidance towards its growth and role in the health care. Medical care slowly but steadily moved towards commodification with profit being the single driving force.

With the public expenditure on health not increasing and even worse sliding to settle on a declining graph, the private sector in health care assumed a larger role with its share of utilization on ambulatory care reaching almost 80 per cent by the close of nineties. In this new scenario, the state projected a larger role and involvement of the private sector in the provision of health care leading to some new developments like recognizing the importance of private and voluntary sectors and encouraging their participation in some national programmes. (The central government in 1962-63, introduced a scheme to involve private medical practitioners in conducting voluntary male sterilizations. The scheme was reintroduced in 1978. In 1982 it was extended to private medical practitioners of allopathic medicine and integrated medicine top allow them to conduct vasectomy operations and Intra-Uterine Device (IUD) insertions in their clinics or nursing homes). There were also other forms of concessions extended to the private sector in the form of reducing import duties on high technology medical equipment, special concession given to NRIs (Non-Resident Indians) and Trust Hospitals and research institutions and recognition of hospitals as industry thereby making them eligible for loans from nationalized banks. The private health expenditure now accounts for almost 6 per cent of GDP.

Another level of relationship-building and interconnectedness between the public and the private took place when the public sector undertakings started recognizing certain private nursing homes for treating their employees. The companies started reimbursing the cost of treatment to the employee. This trend inflated the cost of medical care since the cost on services incurred would be reimbursed later.

The level and range of interconnectedness between the public and the private has had its implications on the access to services and the quality of care, especially since the growth of the private sector has been largely unregulated. The poor health indicators stand testimony to the lack of proper health planning and policy in the country. The macro and micro-data clearly highlights the differential health outcomes among women, children, aged, scheduled castes and tribes, and other groups/ communities. The health gaps between different groups and communities across regions (rural/urban) and state is increasing by the day.

Beginning of the end

Crisis in the health system due to the presence of private interests exists. There are doctors working in the public sector who indulge in private practice. Again, when most of the health personnel are trained through state expenditure, their joining the private sector or migrating to developed nations is tantamount to huge loss to the State leading to crisis within the public health system, both financially and human resource-wise. The range of available private providers is varied and huge that comes from the various formal and informal systems which include qualified practitioners of different systems of knowledge to traditional practitioners. Data of the entire range of practising practitioners is inadequate.

A concern related to the growth in private markets is that of equity. Privatization always has considerable distributional implications. The main argument that is particularly relevant for the social sector is that privatization of the health care creates inequity by making access to crucial, life-threatening services dependent upon ability and willingness to pay. The World Bank argued otherwise. It suggested that privatization policies will actually enhance equity by bringing in new resources so

Reasons for the drift from public provision to private sector are mainly related to the problems of service quality (restricted opening times, rude staff, lack of drugs and equipment, poor facilities, illegal charging), and lack of accessibility, particularly in rural areas where facilities are spread thinly. As a result, the poor make extensive use of the private sector.

that governments can focus its efforts upon poor and essential services and thereby expand services and increase access among the previously unreached. Evidences emerging from across the globe do not substantiate this argument.

Reasons for the drift from public provision to private sector are mainly related to the problems of service quality (restricted opening times, rude staff, lack of drugs and equipment, poor facilities, illegal charging), and lack of accessibility, particularly in rural areas where facilities are spread thinly. As a result, the poor make extensive use of the private sector. In the light of the complexities of what constitutes the private sector, this is not very illuminating for policy purposes. Irrational therapeutics, over-prescription, unnecessary use of injections and over-investigation are pushing the cost of health care beyond the reach of the poor. Debt and poverty due to illness and cost incurred on medical expenses are adding fresh numbers to the already existing large proportion of poor in the country.

Conclusion

There are debates on whether the government interventions to ensure a regulated and monitored private participation should be most or least intrusive. Government's role in the health sector depends on the society's values, inherited structures and political processes. The extent and significance of the role of the government depends on the long-term measures that it takes to establish coherent institutional arrangements that necessarily goes on well beyond the health sector reforms. There is a historical segmentation and hostility towards the private sector and weak institutional capacity among the developing countries that impedes a healthy relationship between policymakers and the existing private sector. In a few cases, where interaction happens, it happens in a very ad hoc manner. A review of the well-performing health systems that have substantial private delivery consistently reveals a set of good institutionalized policy instruments to deal with the private sector.

A strategy for enhancing the participation of existing private providers is to improve health services regulation. Regulation is often considered a means of improving quality of care and ensuring minimum standard of care received, thus reducing inequality and disparities in quality or access (geographic or economic) to health care. It can also be used to improve technical and allocative efficiency and to reduce waste and corruption. Finally, regulations can cut down costs, thus contributing to the financial sustainability of the health systems. In India, a few states have acts to regulate the private sector but none of them have been effectively implemented.

Regulation is more than laws and directives. Effectiveness of health care regulation is directly related to the way the processes and institutions are structured. Any efforts to enhance the regulatory framework would involve a balanced package of controls and incentives. Despite all the technical criteria, regulation is inherently a political and cultural process. Efforts to improve regulation must necessarily build on a transparent interaction between the regulators and the regulated. Private participation can be successful only in an environment of raised awareness of service quality and consumer rights.

Chaotic markets thrive where governance has failed. Unorganized markets have their own histories and political economies and they are not only used by the poor but do them the greatest harm. They suffer the greatest information asymmetries and are much more likely to be at the purchasing end of shoddy or dangerous goods and services. Redrawing the boundaries between mediated and unmediated health goods and services can be achieved by potential strategies such as effective regulation, improved user information and a vibrant consumer protection lobby, besides other things.■

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The author acknowledges various sources which are available on request)

Private Health Care and the Growing Menace of OOPS

Ravi Duggal

Economic development can create conditions for better access to health care as well as better average standard of living and improved health outcomes, but a political economy based largely on private health financing, and especially out-of-pocket spending (OOPS) can create large adversities for health not only for the poorer sections of society but also for the middle classes. Thus the role of public financing becomes critical in both developed and underdeveloped economies.

In most developed countries, where health care access is near universal, public financing, which accounts for a proportion of around 80% of all health expenditures, whether through state revenues and/or social insurance, has been the critical component in realizing universal access with equity. In contrast, in most developing countries the reverse is true, that is between 70-80% of health expenditures constitute OOPS .

The evidence for this in India is clearly brought out in the changes one sees across the 42nd, 52nd and 60th Rounds of NSS Surveys, when over two decades utilisation of private health services, especially in the hospital sector, increases substantially, out-of pocket spending gallops, indebtedness due to healthcare affects nearly half the users and the proportion of non-utilisation also increases. This coupled with poor commitment of public resources to healthcare which has also seen introduction and/or increase in user fees in the last decade is the main cause for poor health outcomes in India.

In fact, when we relate health outcomes with expenditures we see that in comparison to similarly developed countries India's performance is the worst despite having one of the highest total health expenditures amongst these countries as is evident in *Table 1*.

This is largely due to the fact that in India the spending is mostly out-of-pocket because public resources committed are very low. In a scenario of poverty, such a mechanism of financing will never show up good health outcomes because out-of-pocket health expenditures for the poor as well as the not-so-poor means foregoing other basic needs, or worse still, getting into indebtedness. National surveys show loans for health care to be the number one reason for families, especially the poor, getting trapped into indebtedness. This is unflinching evidence supporting the hypothesis of criticality of public financing for good health care and health outcomes. In India the high OOPS, including the user fees in public institutions, is making health care access ever more difficult and contributing to an increasing number of families falling below the poverty line.

The total value of the health sector in India today is over Rs.3000 billion or US$ 77 billion. This works out to about Rs.2600 per capita which is 6.2 per cent of GDP. Of this, about 15 per cent is publicly financed, 3 per cent is from social insurance, 1 per cent private insurance (Mediclaim Policy Premiums, 75% to public sector insurance companies) and the remaining 81 per cent being out-of-pocket resources as user-fees (85 per cent of which goes to the private sector.*(See Table 2)*. Two-thirds of

the users are purely out-of-pocket users and 70 per cent of them are from amongst the poor. The tragedy is that in India, as elsewhere, those who have the capacity to buy health care from the market most often get it without having to pay for it directly, and those who are below the poverty line or living at subsistence levels are forced to make direct payments, often with a heavy burden of debt, to access health care from the market. National data reveals that 50 per cent of the bottom quintile sold assets or took loans to access hospital care. Hence loans and sale of assets are estimated to contribute substantially to financing health care. This makes the need for social security even more imminent.

Table 1

Health Outcomes in relation to Health Expenditure Patterns

	Total Health Expenditure as % of GDP	Public Health Expenditure as % of total	U-5 Mortality	Life Expectancy	
				Male	Female
India	5	17	95	59.6	61.2
China	2.7	24.9	43	68.1	71.3
Sri Lanka	3	45.4	19	65.8	73.4
Malaysia	2.4	57.6	14	67.6	69.9
South Korea	6.7	37.8	14	69.2	76.3

Source: Changing the Indian Health System – Draft Report, ICRIER, 2001

Public financing of health care comes largely from state government budgets, (about 80 per cent) and the balance from the Union government (12 per cent), and local governments (8 per cent). Of the total public health budget today, about 10 per cent is externally financed in contrast to about 1 per cent prior to the structural adjustment loan from the World Bank and loans from other agencies. Private financing is mostly out-of-pocket with a large proportion, especially for hospitalizations, coming not from current incomes but from savings, debt and sale of assets. Insurance contributions, whether for social insurance schemes or as private insurance premiums, constitute a very small proportion as yet but estimated by IRDA to be increasing at the rate of 40% per annum. Insurance as a mode of financing is mainly for the middle and upper middle classes, and with public health care systems collapsing these classes are rapidly shifting to the private sector for hospital care for which they, especially those not covered by any social insurance, are forced to resort to private insurance as a financing mechanism.

Trends in private health expenditure

The private health sector has always been a very substantial entity in India, especially for ambulatory care. However, for hospitalizations until the mid-eighties the private sector was a reasonably small player but since then it grew by leaps and bounds and overtook the public hospital sector around the mid-nineties. From 1970s onwards, private spending on health care grew gradually, peaking around early 1980s. The eighties saw a growth phase of public health investment via the Minimum Needs Programme and hence we see private health expenditures decline during that period because of improved access to public health care facilities. The impact of SAP affected both the public and private health sectors but by mid-1990s the private health sector recovered dramatically and since then it has grown at the cost of the public health sector. *(see Table 3)*

It must be remembered that 80-85 per cent of private health expenditure is incurred out-of pocket, and the burden is directly on household budgets. Further, less than 10 per cent of the workforce is in the organized sector, which may have either social insurance or medical benefits coverage from employers, estimated to cover about 15 per cent of the population. This means that as much as 85 per cent of the population, largely poor and subsistence-level households, contribute entirely out-of-pocket to access private health services and as we have seen earlier this is often coming not from current incomes but from loans and sale of assets. Thus the growing share and control of the private health sector and dependence of even poor households on OOPS as a means of financing health care is extremely hazardous to India's

Table 2

Financing Health Care in India 2007

Type of Financing	Estimated users - millions	Expenditure (Rs. Billions)
Public Sector	300@	480 (16)*
Of which Social Insurance	60	50 (1.6)
Private Sector	800@	2600 (84)**
Of which social insurance	30	40 (1.3)
Private insurance	30	36 (1.2)
Out of Pocket	740	2524 (80)
Total	**1100**	**3080 (100)**

@ Estimates based on National Sample Survey 60th Round, and Labour Year Book
** Finance Accounts of Central and State Governments, and Labour Year Book*
*** Private Final Consumption Expenditure from National Accounts Statistics*
(Figures in parentheses are percentages)

health and development. The high economic growth of the country will have little meaning and impact if the health care access to its people continues to become more iniquitous.

Comparison of utilization and health expenditure data across the 42nd (1987), 52nd (1996) and 60th (2004) Rounds of NSS shows a very alarming trend (Tables 4&5) There is up to 37 per cent decline in the use of public health care facilities for hospital care in both rural and urban areas over this period and consequently increase of 36% in use of private healthcare facilities. Why is this so? Partly the answer is within the same data set. The cost of seeking treatment even in public hospitals has increased over ten-fold. During the same period, purchasing power of the poorer classes has not changed in any substantial way and as a consequence, the 52nd and 60th Rounds show higher levels of untreated morbidity, especially amongst the poorer groups. The other part of the answer is the declining investment and expenditures in the public health sector. It can be argued that these trends are closely linked with a wide spectrum of changes in the economy since the mid-1980s, which have led to privatisation of services, deregulation of drug prices, increased reliance on market mechanisms to address welfare needs, and weakening of public health systems. Thus the main hurdle to health care access is a weak and declining public health sector on the one hand and the continuing high levels of poverty in the changing political economy and the inequities associated with it on the other.

Table 3:

Private Health Expenditure Trends

Year	Private Health Expenditure (Rs.billions)	% of GDP	% of Total Health Expenditure
1975-76	24.66	3.26	78.43
1980-81	52.84	4.06	80.43
1985-86	90.54	3.61	75.32
1991-92	160.65	2.73	74.01
1992-93	175.57	2.61	73.09
1993-94	195.43	2.50	71.78
1994-95	278.59	3.04	76.48
1995-96	329.23	3.07	77.42
1996-97	373.41	3.00	77.35
1997-98	458.99	3.30	78.30
1998-99	653.40	4.04	81.21
1999-00	835.17	4.76	82.91
2000-01	981.68	5.18	84.06
2004-05	1700.00	5.32	83.90
2006-07*	2100.00	5.80	83.00
2007-08*	2600.00	5.40	84.00

* estimates by author

Source: CSO – GOI National Accounts Statistics, 2006

Table 4

Trends in Utilisation Rates of Public & Private Facilities for Hospitalisations (percent)

Type of Hospital	Rural		Urban			
	60th	52nd	42nd	60th	52nd	42nd
Public	42	44	60	38	43	60
Private	58	56	40	62	57	40

Source: NSSO 60th Round – 2004, Report No.507, NSSO, New Delhi, 2006

Table 5

Trends in Average Medical Expenditure per Hospitalization (Rupees)

Type of Hospital	Rural		Urban			
	60th	52nd	42nd	60th	52nd	42nd
Public	3238	2080	320	3877	2195	385
Private	7408	4300	733	11553	5344	1206
Combined	5695	3202		8851	3921	

Source : NSSO, Respective Rounds

In such a political economy scenario of liberalization, privatization and globalization and the reduced participation of the state in health and health care provision and financing, increasing proportion of households are being forced to access private health care with a rising burden of OOPS. While middle classes can find means to cope with this via insurance or employer support, sometimes with severe economic distress, the bottom two quintiles do not have the capacity to board the insurance bandwagon despite various community or universal health insurance schemes that Finance Ministers have launched in the last 5 or 6 years. Since insurance requires contributions, it is bound to fail for the bottom three quintiles who earn less than $1 a day. So it is clear that insurance cannot be an option in India for health care financing; the state has to play a larger role in both financing and provision of health care. That is the only way to curb the growing menace of OOPS which it is estimated, adds at least 2% households each year to the poverty club of India.■

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The author acknowledges various sources which are available on request)

COVER STORY

Recent trends in privatization in health care

Rama V. Baru

This article describes the trends in privatization since Independence focusing on the shifts during the last three decades. It examines how the growth of 'for-profit' sector has resulted in the emergence of newer institutional arrangements like public-private partnerships (PPPs) and redefining the 'non-profit' institutions.

Introduction

The private or 'for-profit' sector in health services has undergone tremendous growth and diversification during the last six decades of Indian Independence. From what was largely dominated by individual providers, it now includes varied institutional forms ranging from small clinics to nursing homes and tertiary, specialist hospitals. This is in a sense unique to India when compared with any of the other South Asian countries where the private sector is largely dominated by individual practitioners. Studies have shown that private practitioners at the primary level consist of a variety that include traditional healers, folk practitioners, herbalists, practitioners of indigenous systems of medicine, allopaths and those practising allopathy without any formal training. There is some evidence to suggest there is considerable amount of cross practice between practitioners, institutions and systems of medicine in the private sector.

Pyramidal structure

The secondary and tertiary levels of care consist of institutions of varying size and ownership patterns. These include nursing homes with bed strength of five to over two-hundred depending on the scale of operation. The smaller nursing homes are owned largely by single owners while the larger hospitals are managed as partnerships, private limited, trusts or corporate entities. This plurality is seen in India and is largely an urban phenomenon but in recent times this segment has grown even in rural areas in the more prosperous states of the country. In fact, one could characterize the structure of the private sector as pyramidal, with the base consisting of the large number of individual practitioners who may be trained or untrained. The middle level is occupied by institutions providing both out-patient and in-patient care and promoted largely by a single entrepreneur, mostly doctors. These are mostly located in urban areas but in some states they are located in towns and even villages. The apex of the pyramid is occupied by large hospitals that are promoted as trust, private limited or corporate enterprises. These offer super-specialty services and are located largely in the metropolises. This segment would constitute roughly around one percent of the total beds

in the private sector.

Significant presence of private sector

The importance of analyzing the dynamics of the private sector derives from its significant growth and its utilization for out-patient and in-patient services across regions and classes. A number of studies have analysed macro-data sets like the National Sample Survey, National Family Health Survey that have shown a considerable reliance on the private sector. The last four decades have seen the expansion of the private sector in health. A lot of the public debate and research has focussed on the private sector in the provisioning of medical care. The significant presence of the private sector at the primary, secondary and tertiary levels of care is well acknowledged as shown by a number of studies. A number of micro-studies on utilisation has infact highlighted the dependence of different strata of a given population on private practitioners, both trained and untrained, for primary level care across states (Bisht:1993; Soman: 1992; Krishnan:1994; Kakade:1998). These studies have shown that there is plurality among the private practitioners ranging from untrained practitioners dispensing allopathic medicines to a range of practitioners who practice traditional, folk and indigenous systems of medicine. Many of them dispense allopathic medicine along with traditional cures. These practitioners are not restricted to urban but their presence is extensive even in rural areas, (Vishwanathan &Rohde: 1990). Analyses of the various rounds of National Sample Survey data on utilisation of medical service in fact corroborate the findings from a range of micro-studies. For minor ailments, majority of the people use the services of the private practitioner. This was seen in both rural and urban areas and across states.

With growing privatization, the focus has been on the 'for profit' sector and as a result there has been little attention paid to the 'non profit' sector. The latter has a long history and is extremely plural in terms of ideology and institutional forms. Influenced by a plurality of ideologies — religious, socialist, Gandhian etc — this sector grew prior to independence and was not paid any attention by state policy and later was engulfed or marginalized by the growing private sector.

Utilization pattern

When it comes to hospitalization, the picture is more complex. Here the extent of growth of private medical care at the secondary and tertiary levels, its variations across states and the differential purchasing power across various strata determines the utilisation pattern. For example, the analyses showed that the economically developed states had a higher utilisation of the private sector and those who used these services were largely from the middle and upper middle income groups. In states where the secondary level of the private sector was not significant, the utilization of the public sector was very high.

The National Sample Survey data on utilisation of medical services conducted during the mid 1980s and late 1990s shows that majority of the population, across states and rural/urban areas, are dependent on private practitioners for out-patient care. This picture is however mixed with respect to in-patient care across states. In those states viz. Kerala, Punjab, Gujarat, Maharashtra, Andhra Pradesh, where there is a considerable presence of the private sector at tertiary and secondary levels of care, the proportion of the population utilising private services is high. Analysis of the 42nd round shows that across states there is a high dependence on the private sector for out-patient services in both rural and urban areas. Here the out-patient services are provided by a plurality of providers, both trained and untrained. The picture on utilisation is more mixed when it comes to hospitalization across states. The major trend during the mid-eighties showed a high reliance on public hospitals for major illnesses at the All India level but there were significant inter state variations. States like Andhra Pradesh, Maharashtra, Gujarat, Kerala, Tamil Nadu that have high private sector growth, there is greater reliance on the private sector for hospitalization. The utilisation of the private sector corresponds to income levels viz. the higher and middle income groups use it more than the poorer sections. (Baru:1998) During the mid-nineties, what is significant was the rise in costs of medical care in both the public and private sectors and also a greater reliance on the private sectors, (Iyer and Sen:2000).

The reason for this kind of a pattern stems from the fact that several state governments have introduced user fees in public sector hospitals and at the same time the private sector has increased its outreach into peri-urban

and rural areas. Often, the employees in the public sector have links with the private sector that results in cross referrals.

Public-private partnerships (PPPs)

A new institutional arrangement that has gained legitimacy in health policy is the public-private partnerships. The idea behind these partnerships is to "marry the best of public and private sectors" in order to promote greater efficiency. A number of partnerships have been initiated at all levels of services and across states. Typically, these are in the form of contracting-out of services and social franchising for creating demand for services. These partnerships have redefined the boundaries between market and state in health services and legitimized the former's role. Based on an indepth analysis of the existing partnerships in health, Baru and Nundy observe that: " In India, majority of PPPs have followed the contracting-in and contracting-out designs and have been for specific inputs like services, health education and demand generation through social-marketing. Other forms of PPPs like social franchising and joint ventures involve much more complex designs and are fewer as compared to the contracting models. A closer look at the existing partnerships suggests that they are quite complex involving multiple actors with multiple and overlapping roles thus blurring the traditional boundaries of the state and market" (Baru & Nundy:2007). These arrangements not only blur the boundaries between market and state but have an impact on reshaping the values of institutions. For example, the introduction of market principles into public institutions legitimizes paying for services and moves away from the perspective of health as a right.

Impact of privatization on the 'non-profit' institutions

With growing privatization, the focus has been on the 'for profit' sector and as a result there has been little attention paid to the 'non profit' sector. The latter has a long history and is extremely plural in terms of ideology and institutional forms. Influenced by a plurality of ideologies — religious, socialist, Gandhian etc — this sector grew prior to Independence and was not paid any attention by state policy and later was engulfed or marginalized by the growing private sector. The case of missionary hospitals — history of their growth, values for which they stood; the excellent institutions that they created and managed to provide good care at reasonable cost — has been largely unrepresented. 'Non profit' health institutions that were established during the late 19th and early 20th centuries have either closed down or adapted to the changing situation by becoming more commercial. There are instances of many of these 'old trust' hospitals that have contracted out their management to corporate bodies in recent times. While there has been a general neglect of the old trust institutions, the corporate hospitals have pressurized government to give tax concessions by giving them a trust status on the grounds that they carry out research that is for public gain. An examination of many of these hospitals shows that there is neither any public presentation of the research nor do they abide by any equity principles for treatment purposes. Government policy has never addressed the need or role of these institutions in health services delivery when this sector could have been a viable alternative to the commercial sector.

Conclusion

This paper has reviewed and analysed the growth and characteristics of the private sector in medical care. The private sector has grown and diversified over the last three decades and has emerged as an important actor in the provision of medical care in both rural and urban areas albeit the variations it presents across states. It has also shown that the private sector is a heterogeneous entity offering services of variable quality and that in recent years it has been gaining visibility and legitimacy in the health policy. A representation of this trend is seen in the case of public-private partnerships wherein there has been a redefinition of the role of state institutions. The growing private sector has not only redefined the role of the state but also the 'non profit' sector which could still be a better alternative to the 'for profit' sector in delivering health services.■

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The author acknowledges various references which are available on request)

Findings of a study to determine the family burden of caregivers of mentally ill people attending community mental health centres, with special reference to Thiruvananthapuram District, Kerala

Assessing burden of care-giving

Jiji.T.S. M.S.W, M.Phil

This study is aimed at assessing the caregiver-burden of informal carers i.e. family members who are actively involved in the treatment and care of a sick family member who is getting treated in the community itself. The researcher took three Taluks of Thiruvananthapuram District of Kerala State where the district mental health programme is functioning effectively.

From time immemorial, family has played a vital role in the development of the personality of an individual. Parents particularly play a crucial role in shaping and caring for young ones in all possible ways. The family comes under stress when any of the members has special needs due to any sort of impairment, either physical or mental. Olshansky (1982) has speculated that almost all persons who take care of a mentally ill person staying in the family suffer from chronic sorrow throughout their lives. The extent of this sorrow may differ from one person to another but most will have manifestation of sorrow in varying degrees. Family's reaction to stress is highly variable ranging from healthy adaptation to maladaptation. The stigma of mental illness is one of shame and inferiority, which makes the person tainted and discounted. For any mentally ill person and family, the most devastating consequences of being mentally ill are often not the direct physical or mental results of impairment itself but rather the attitudes and reaction of those in the society.

Families play the primary care-giving role for which they have virtually no training. The family burden of care-giving leaves them at risk for stress-related physical and emotional problems. The strain experienced by care-givers of mentally ill people leads to structural changes in the family including changes in life-expectancies, sibling relationships, marriage, delayed launching of children into independence etc.

A study by Mcgilloway, Donnally and Nicholas showed that women are significantly more likely than men to experience poor mental health. Patterns and William(1987) examined 'who exactly are the caregivers'. It was found that spousal caregivers are significantly more likely to provide assistance to the patients as compared to other family care-givers.

Statement of the problem

In common parlance, we can say that if we are facing a stressful situation which is constantly with us, the stress due to that will be much more than when it is away from us i.e. not constantly with us. Here, the stressful factor is the mentally ill person who is staying with the care-giver and the stress caused by him/her is the burden experienced by their caregivers. Here the care-giver is an active participant in the treatment and care of a mentally sick one because the sick person is staying with them, and is not in a hospital.

The person who takes care of the one who is mentally ill has to suffer a lot due to the incoherent behaviour of the patient, i.e. his / her routine caring, including personal care such as bathing, brushing, dressing, diet, medication etc. If the care-giver is the head of the family, may it be husband or wife, his/her workload becomes unbearable due to various other household responsibilities besides caring for the patient like education of the children if any, their marriage, finding a source of income for their

future existence and so on. Moreover, the social attitude and approach towards such a family will be really painful. It gets branded as a mentally abnormal family and the members need to cope with that.

If there is a mental patient in a family, all those who are closely related to that person, i.e. husband, wife children, siblings etc will face difficulty to enter into a new relationships, especially through marriage. Nobody ever wants to shoulder the responsibility of such a person. Since mental illness is related to heredity, even if a family is financially sound the chances of getting a good alliance for other members get curtailed by the presence of a victim in the family.

Thus the caregiver of the mentally ill person is subjected to both internal and external pressures. Internal pressure includes the stresses and tensions he/she experiences within the family, while external pressure includes the stigmatic approach of the society. Sometimes these care-givers may not be in a position to manage the demands of the patient as well as their other dependents. In such a situation, their mental agony will be twice that of what they experienced in those circumstances where they were able to manage to some extent.

Objectives of the study

- Assessing the burden of care-giving of family care-givers of mentally ill patients.
- Identifying various contributing factors in the causation of burden of care-giving
- Determining the difference in the burden of care-givers of both gender

Hypotheses

- There will be significant differences in the burden of male and female care-givers.
- There will be significant difference in the burden of care-givers of patients with different diagnoses.
- As duration of illness increases, burden also increases.
- Higher the education of care-givers lower the total burden of care-giving.

Methods

Family care-givers (N=100) of schizophrenics (34%) bipolar disorder-affected (44%) and mentally retarded(22%) in the age-group of 17 to 70 years were selected from the out-patient clinics of three Taluks in Thiruvananthapuram District of Kerala. Care-givers of neurotics were excluded. 54 males and 46 female care-givers were interviewed. All the care-givers were staying under the same roof with their care-receivers at least for one year.

Tools used

Burden Assessment Schedule was used to collect the personal profile as well as other relevant information of the patients and the care-givers. The schedule contained 40 items, each rated on a 3-point scale. Items were given the score of 1- *not at all*, 2-*to some extent* and 3- *very much*. Negative items were reversely scored. High score was indicative of high family burden.

The collected data was analyzed with SPSS Windows version 11.0. The respondents were divided into 3 categories such as caregivers of schizophrenics, bipolar disorder-affected and mentally retarded. The family burden score was divided into low, medium and high. Percentile analysis was done to categorize them on the basis of scores. T-test was applied to test the significance and validity of proposed hypothesis. Correlation analysis was done to find out the relation between the dependent and independent variables. ANOVA test was also applied to find out the combined effect of independent variables on the dependent variables.

Results

Based on the duration of illness, there were 51 respondents in the first category (1-10yrs and below), 33 in the second category (11-20 yrs) and 16 in the third category (21yrs and above). Only 53% have primary level education, 35% have high school level and 12% have pre-degree and above level education. Majority had lower socio-economic status. There was significant difference

Table 1

Mean and standard deviation values with respect to diagnosis

Diagnosis	Mean	Standard deviation value	No of cases
Bipolar	77.61	10.61	44
Schizophrenia	75.65	11.03	34
M.R	68.41	14.76	22

Table 2

Comparison of mean values with respect to diagnosis

Diagnosis	Mean	Standard deviation value	T-value
Bipolar Mental	77.61	10.59	
retardation	68.41	14.75	2.859

**significant at 0.01 level*

Table 3

Comparison of the family burden means

Gender	Mean	Standard deviation value	T-value
Male	76.93	11.73	1.786
Female	72.57	12.04	

in the family burden scores of persons with bipolar disorder-affected (77.61) and that of mentally retarded (68.64). Likewise, the family burden score of male and female carers were significantly different. (76.93 and 72.57)

Table4 **Correlation values of variables**

Family burden

Variables	P value	Correlation coefficient
Duration of Illness	0.024	0.2256
Education	0.443	- 0.0776
Income	0.002	-0.3100

The study shows significant difference in the burden of the male and female care-givers. The t value is 1.786 that is significant at 0.01 level.

When correlation analysis was conducted between duration of illness and family burden, the value of the correlation co-efficient was found as 0.2256, that is significant at 0.01 level. It means that as the duration of illness increases, the family burden also increases. It shows that there is a positive correlation between these two variables. The prolonged nature of the illness seems to aggravate the difficulties as well as the challenges faced by the family members to live in the society. The result has been supported by the findings of Perlick and Clerkin (1995) in their study on burden of caregivers of chronic mentally ill person. They also came to the conclusion that as the chronicity of illness increases the burden of caregivers also increases.

There is negative correlation between income and family burden. As income increases, family burden decreases. The co-relation co-efficient value was found to be as 0.3100. In the case of correlation between education and family burden, there is a negative relation between these two variables, which is significant at 0.01 level. The ANOVA result showed that the most significant variable in the causation of high family burden was duration of illness, and the least significant variable was education of the carers.

From the ANOVA table, it can be seen that the highest F-value (5.612) is found for diagnosis and that is significant at 0.005 level. It shows that type of illness has got a major role in the causation of total burden of the caregivers. The second higher significance is found for income. The third higher significance is found for the duration of illness. As long as the illness lasts the family has to take care of that sick person including his/her treatment and other needs of that person. The presence of such a person itself leads to many inconveniences in various aspects of life. And if that dependent stage lasts for long, we can assume how it will worsen the situation.

> Families play the primary care giving role for which they have virtually no training. The family burden of care-giving leaves them at risk for stress-related physical and emotional problems.

Discussion

The study has proved that the carers of those affected with bipolar disorder are having the highest family burden than that of schizophrenics and mentally retarded ones. This finding has been supported by the study of Perlick Deborah (1995); their study was on the burden of caregivers of chronic mentally ill persons. The findings of the study that as the total duration of illness increases, family burden also increases was well supported by the study of Ross and Linda(1996) on the families of psychiatric patients in the John Hopkins University.

Despite limitations, the findings of the study are found to be quiet relevant to make a comprehensive psychiatric intervention for family care-givers which would go a long way in reducing the burden of care-giving. ■

Table. 5

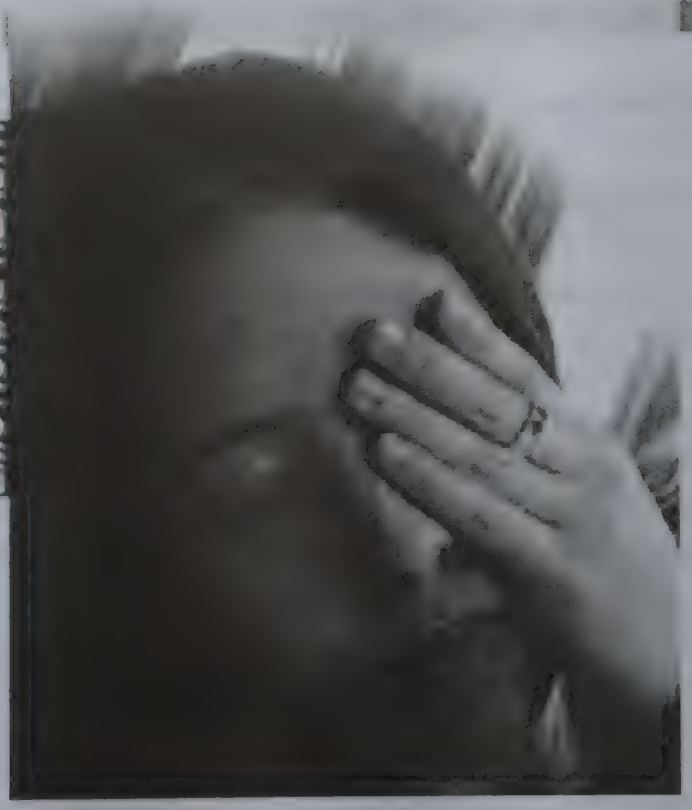
Combined effect of all independent variables

Family burden

Major variables	Mean value	F value	Significance
Diagnosis	635.181	5.612	0.005
Duration of illness	569.480	5.031	0.008
Education	27.566	0.244	0.784ns
Income	630.469	5.570	0.005
Gender	464.521	4.104	0.046

(Research Scholar in Social Work in the University of Kerala, Thiruvananthapuram

The author acknowledges various sources which are available on request)



Dealing with Bereavement

Rev. Dr Tej Lal, IMS

There is a word "reave" meaning deprive somebody of something, belonging to oneself. For instance, when some restrictions are imposed on a sick person he/she has to change his/her way of living and working, something is taken away from him/her — his/her rightful choices and decisions that previously belonged to him/her. When parents lose a child either by death or any other way, they are dispossessed of something very precious. When a person undergoes the ordeal of divorce or suffer the loss of a loved one through death, they are left with a sense of having suffered a robbery or dispossession.

Irrevocable injury of any sort like rape, chronic illness, birth of a defective child, breakup of a love affair, loss of job, loss of a long-cherished dream, permanent damage to one's property, and separation from one's dear and near ones. The ultimate dispossession, perhaps, is facing the loss of one's own life.

There is a kind of grief which is not always there in an individual. It is often aroused during treatment. The patient realizes that he/she is from a broken or alcoholic family or the parent was mentally ill and could not get the love he/she always yearned for. The events of the past are unalterable. A sense of loss may be experienced as a permanent loss amounting to a death-experience.

Losses of significant magnitude are a part of life. We pass through stages of life with all kinds of dreams and seriously think they are within our reach. But the truth is that in pursuing some of our dreams, we leave others behind with sometimes a deep sense of discouragement. But the reality is that there are choices to make and in the process of selection some are chosen and others are left out. Though events are of our own selection or rejection, we do come to realize our own limitations and such a realization hurts us.

Sometimes, we ourselves come through our own losses. Understanding and making peace with personal losses is an essential requirement with those who are involved in grief counselling. If I am ashamed of my own tears, I can hardly help others who are ashamed of their tears. Explosive attitudes are to be controlled by calmness and gentleness. Unless I realize that it takes months and sometimes years to heal my own wounds, I would lack the patience to go through the pains of my own clients.

I don't think that anyone would think that all are free from pains big and small. Vulnerability to suffering is a fact of our human condition. The therapist need not share his personal losses with the clients. Such an approach may not be effective in grief counselling but we should take our own losses seriously and should avoid living in a fantasy world that we are immune from every kind of losses and pains. Facing one's own pain of losses is part of how a person becomes comfortable enough to help to face pain of loss in others.

Grief and fear

There are people who feel that grief is a mental illness. When people suffer from sleeplessness, anxiety, fear, intense anger, loss of interest in activity, sad feelings and preoccupation with self they think that they are going crazy. But these things can be symptoms of a normal grieving process. In such cases, what a client needs is an experienced counsellor who is knowledgeable about grief and is empathic.

For example, a person who has lost a lover or a marriage partner, will specially notice every couple and will feel that all couples are happy except himself or herself. If a woman suffers a miscarriage, every pregnant woman or

every little child she meets is a reminder of her loss. The preoccupation with her loss is much more intense in the earlier months. The grieving person would search through things associated with the loss -- old photos, letters, or other keepsakes -- over and over again.

Preoccupation is not a sickness but part of the normal process of separation. One need not throw away cherished things to keep oneself from preoccupation until feeling ready to do so. Often, people regret much after throwing away the reminders of the loss.

Hallucinatory experiences are quite common in cases of serious losses. Like a person hearing the footsteps of his diseased sweetheart and getting the smell of the delicious food she used to prepare while opening the door of the kitchen. And this, many years after her death. Hallucinations are much stronger in the early months of the loss. A teenager used to tell me that he saw several times his dad in the baseball court though he was dead several months before these hallucinations occurred.

Things will never be the same

Loss changes the lives of people. The will never be the same. I don't mean that they can never be happy. But we do see changes in their human relationships and one has to accept those changes.

One of the most difficult realities of grief involves the loss of potential. When a person loses an organ, gives up a child for adoption, has an abortion, ends a marriage or suffers the loss of job, a whole world of potential comes to a stop. Now he has to develop an entirely new life and a new growth. Growth faces frictions and oppositions but one has to go ahead facing new challenges. The long-time-learned patterns of life may not be of any use in the new situations.

Feelings of guilt and self-blame

Most of us take care of our loved ones in the best way possible, still there may be the feeling that we have not done enough. We would tell ourselves that we should have looked for better doctors and better hospitals and our loved ones may have lived for a few more years. Guilty feelings are almost inevitable in the presence of loss. Guilt is felt as if the person had intentionally brought harm to him or herself or to another.

The counsellor needs to give sufficient time for the grieving person to explain his/her side of the story. Comforting the client by reassuring too soon may hurt him/her. The client may shut down his or her expression of guilty feelings. But he/she would still think on and off: "If only I had told the whole story to the counsellor, he would have understood why I'm to blame." For this

> We pass through stages of life with all kinds of dreams and seriously think they are within our reach. But the truth is that in pursuing some of our dreams, we leave others behind with sometimes a deep sense of discouragement.

reason, it is important for the counsellor to listen to the complete account of the client's guilt and acknowledge the troubling feelings of the client. Gradually, the counsellor would be able to make the client realize the unrealism in his/her feelings and thinking. Finally, the client will realize that whatever was humanly possible under the existing circumstances, he/she had done. This will enable the client to view the events that lead to the loss with more self-compassion.

Guilt and self-blame are only realistic when there is a real negligence involving direct responsibility. For example, leaving a child unattended as a result of which the child was victimized, or driving under the influence of alcohol or other drugs, or driving at a very high speed resulting in a serious accident. Here the guilt is realistic. In such cases, the feeling of guilt is almost unbearably bitter. In such cases, often, the client passively denies that such a thing occurred. This is how he/she survives the assault of guilt.

People sometimes, both in real as well as in unreal guilt, become self-destructive. They punish themselves for the event they feel responsible.

Realistic guilt calls for a counsellor who believes in a loving and forgiving God. The counselling process is made richer when it is based on faith in God who forgives human tragedies. A spiritually-based counsellor can be especially helpful when the client is struggling with realistic guilt. When the client shares the painful feelings of remorse, the counsellor listens respectfully, acknowledging the feelings, but most of all communicating a silent, caring presence.

Physical symptoms of loss

An experience of loss is marked by a number of physical changes. Our bodies have more than a dozen ways of weeping with us. Headaches, digestive problems, aching of limbs, insomnia, irritability, moodiness, restlessness, loss or increased appetite are some of them.

(Continued on page 27)

Common Salt
A most important condiment

Satya Bhama and SR Malhotra

Salt has been an essential, virtually omnipresent, part of medicine for thousands of years. Salt symbolizes life itself. Human life without salt is unimaginable. Salt is a biological necessity of human life. It has been used as a remedy, a support treatment and a preventive measure. But we live our daily lives practically unaware of this basic biological fact.

Basic physiological functions depend on a balance between salts and liquids in the body. When this balance is upset, disease may occur. Salt is involved in regulating the fluid balance of the body.

Salt is the most widely used seasoning in the world. Its flavour is one of the basic tastes. It intensifies, brightens, heightens and improves the taste of every dish in which it is added. In food processing, salt is used as preservative.

Iodized salt is simply table salt with iodine added (to help prevent hypothyroidism). Though salt is required for life, over consumption can increase the risk of health problems like high blood pressure in those individuals who are genetically predisposed to hypertension.

Iodized and uniodized salt are sold simultaneously in the country. But the awareness of the health priority aspect of iodized salt among the public has resulted in the creation of a significant consumer demand for iodized salt. In fact, it is needed to make awereness compaigns to create more demand for iodized salt and consequantly the success for the iodine deficiency disease control programme.

Types of salt available in the market

Rock salt: Rock salt can be used in ice-cream making or as a base to serve oysters over, but is most often ground down into kitchen salt (fairly coarse) or table salt (finely textured).

Kosher salt: Kosher salt is a coarser, additive-free salt. Like sea salt, it is preferred by some for its taste, but is also used by some in accordance with Jewish law.

Pickling salt: Pickling salt is also additive-free and is used for making pickles.

Black salt: Black salt is actually grayish-pink when ground, smokier than regular salt and is often found in Indian cooking. Black salt is used especially in salad for its good taste.

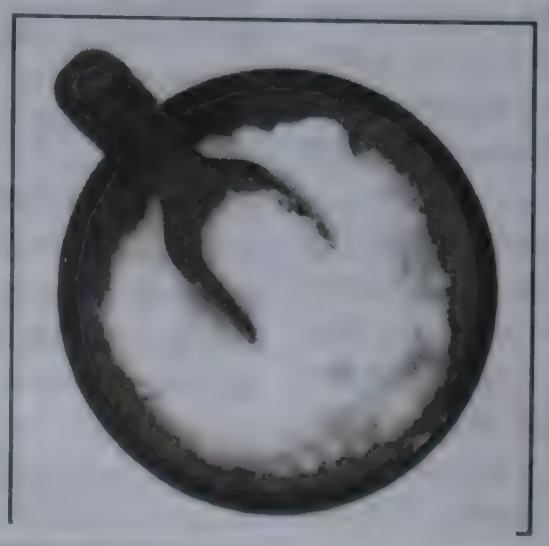
Storage of salt

Keep salt in an airtight container in a cool, dry place and away from fire. Do not allow salt to remain in long-term contact with silver (shakers or spoons) as it will turn green. A few rice grains in your saltshaker will help prevent your salt from becoming damp, if exposed to humidity.

Recommended iodine intake for varies age-groups

- Infants (0-12months) - 50ìg
- Children 2-6 yrs - 90ìg
- 12yrs and above - 150ìg
- Lactating and pregnant women - 200ìg

In 1993, WHO and UNICEF recommended Universal Salt Iodization (USI) as the main strategy to achieve elimination of iodine deficiency disease. In all countries where iodine deficiency occurs it is well recognized that the most effective way to achieve the complete elimination of IDD is through universal salt iodization which involves the iodization of all human and livestock salt including salt used in food industry. National iodization programmes are now applied world-wide a common pattern of evolution is followed which includes the following phases.



Iodate is recommended in preference to iodine

Potassium iodate and potassium iodide are used for fortification of salt. Potassium iodate is used for fortifying salt than potassium iodide because of its

greater stability, particularly in warm, damp or tropical climate. No data are available for indicating toxicological hazards from the ingestion of these salts below the level of provisional maximum tolerable daily intake.

The actual availability of iodine from iodized salt at consumer level can vary over a wide range as a result of variability in the amount of iodine added during the iodization process.

The extent of loss of iodine is due to impurities, packaging and environmental condition during storage and distribution, loss of iodine due to food processing, washing and cooking processes in the households.

Fortification with iron

Salt is considered an eminently suitable vehicle for iron fortification in India as it satisfies all the criteria for an ideal vehicle. Salt is consumed by all segments of the population, rich as well as poor, perhaps more by the poor. Salt consumption lies within a narrow range of 12-20g/day with an average intake of 15g/day/person. Of the estimated annual production of 7 million tons of salt about 4.5 million tons are estimated to be available for human consumption, most of which is produced in about 120 manufacturing centres, mostly in two states of India — Gujarat and Tamil Nadu. Most of the salt consumed in India is in the form of crystals. In recent years, sale of powdered salt in packets has been increasing. In India, edible salt is manufactured mostly from the sea and it is relatively crude, containing as much as 4% moisture and impurities like magnesium and calcium salts. The high moisture content in the presence of magnesium salt poses several technical problems in fortifying salt with iron.

Sources of salt

Motivation for salt refining – It is not too hard to see that the processing of salt renders it a "junk food." The primary use of salt is not as a food additive, but for industrial purposes. Only 7% of salt manufactured goes for food; the other 93% goes to industry. Industry requires chemically pure sodium chloride for the manufacture of explosives, chlorine gas, soda, fertilizers and plastics. Since refined table salt is formulated specifically for industrial and chemical usage, scant concern is given to its toxic effect on human biology.■

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(Continued from page 25)

Some have acute anxiety attacks, dizziness and shortness of breath. Studies have shown that people in their thirties and younger show more physical symptoms in the process of mourning than older people.

The first three months of bereavement are most difficult to go through. During this time, it is highly beneficial for a person to see a physician, especially if he/she goes through a high number of intense life-changes. Slowly, the physical symptoms show improvement.

Anger and bitterness

I was appointed pastor of a Church in East Texas and hardly one month passed when I received the sad news that 18 year-old Joe shot himself in his own classroom. I rushed to the school and then to the hospital. Joe was on the operation table struggling for breath. I sat close to the parents of Joe, just outside the operation theatre. I thought I had come to console them but their parental reaction was not what I expected. Joe's mother repeated several times angry statements: "He has always caused me trouble, and now he has done it again! How can he do this to us? She angrily repeated every worry Joe had given to them. Their only son was on the operating table and they're angry at him!

Trials of all kinds generate anger in human beings. For some, the anger is directed against the specific cause and in others it is spread out to different directions or a kind of generalized fury. There are some others who hold the anger tightly within themselves.

Anger is unavoidable in bereavement. At times, the client turns the anger towards the counsellor. In such cases, the best thing the counsellor could do is to listen, ask questions for clarifications and reflect back the client's angry feelings. Counsellor defensiveness is counter-productive. The client is given the impression that his/her feelings are not taken seriously by the counsellor. Tears have a tremendous therapeutic value, physical activity and vivid fantasy are also a very valuable means to reduce anger.

Some clients express deep yearning to be able to weep. Counsellors should encourage the clients to weep and thus they could weep the sorrow and anger out of their system. Anger and bitterness can be a good sin. These strong emotions often signal that the healing process is well under way. Once the person is openly angry, many feelings such as shock, fear, feelings of ruin, long period of depression, guilt etc. are projected outwardly. The bereaved person is mobilizing his/her energy once again. The grieving person is fighting for life and that's a good sign. ■

(The author is in-charge, Pastoral Care Department, The Catholic Health Association of India, Secunderabad)

Poverty of Health

Though improving, our health indicators are poor when compared to those of the developed countries.

Partha Sarathi Datta

In developing countries like India, we generally see that some or most of the health indicators are improving over the years and we do appreciate that. But if we compare those health indicators with the health indicators of developed countries, we can see the real picture — there are vast gaps. Say for example, if we look at the Infant Mortality Rate (IMR per 1000 live births), in India, it was 102.0 in the year 1981; 86.0 in 1987; and 62 in year 2004. So, it shows that the trend in IMR is declining gradually in India over the years. But now, if we compare the same with that of other developed countries, we can see that in the same year, 2004, it was between 4.0 to 6.0 in the developed countries like Canada, Denmark, France, Germany, Italy, Netherlands, Spain, UK and USA but it was 62.0 in India in the same year.

Similarly, in India, Neonatal Mortality Rate (NMR) was 60.0 in the year 1981, 53.0 in 1987 and 43 in the year 2000. So, the neonatal mortality rate decreased over the year in India during the years 1981 to 2000. But when we compare the same indicator of health with the other developed countries like Canada, Denmark, France, Germany, Italy, Netherlands, UK and USA, we find that in the year 2000, Neonatal Mortality Rate (per 1000 live births) was between 3.0 to 5.0 in the above-mentioned countries, whereas in India it was 43.0 in the same year. In 2004, Prevalence Rate of Tuberculosis was <10.0 in Canada, Denmark, France, Germany, Italy, Netherlands, UK and USA, but it was 312.2 in India.

Although some of the health indicators are gradually improving over the years in our country, still we are very poor at reaching that level compared to the health indicators of the developed countries.

Similarly, if we compare the health indicators of the various states of India, we can notice that there are significant differences among the states. Say, for example, if we see the Crude Death Rate in Kerala in the following table, it is 6.40, whereas in UP. It is 10.5. Similarly, IMR in Kerala is 14, whereas in UP, it is 84. Completed Immunization is about 80% in Kerala but in UP it is only 21%.

Item	Uttaranchal	Kerala	U. P.	India
Crude birth rate	26.0	18.00	32.80	26.0
Crude death rate	6.50	6.40	10.5	8.7
Infant mortality rate	52.00	14.00	84.00	70.0
Total fertility rate	3.06	1.96	3.99	2.85
Complete Immunized children	40.9%	79.7%	21.2%	42.0%
Safe delivery	51.2	97.4	20.8	40.2
Unmet need for Family planning	21.0	11.7	25.1	15.8
Women with Children 3 and above.	51.1	17.3	59.9	45.8
RTI among women	41.2	42.4	38.1	34.0
Institutional delivery	18.1	97.0	16.2	34.0

The intervention therefore needed is not just on poverty but on other specific issues also. The future trajectory of the global health epidemics largely depends on whether the world can reduce the poverty of health all over the world in which India is not an exception. It is possible to underestimate the challenges of poverty of health in India as the country is developing but high population with low literacy rate, low income and low health infrastructure, consequently encourages high level of poverty of health compared to other developed countries. The increasing poverty of health in India definitely contributes to the increase of poverty of health around the world.■

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Training Models

Fr J Murickan Ph.D

Imparting new skills, upgrading existing skills or correcting skill deficits are all attempted by training models. Developing the right model for imparting these skills is attempted in designing training models.

Of all these goals, reforming deficit skill sets are most problematic since that entails unlearning an old habit and re-learning a new set of behaviours.

While structural and interventional training do take place in formal education, a suitably customized training model is designed for employability in a particular segment.

Thus most available formal training methods and processes need to be repaired for employment suitability and application in different job markets. Different models have to be designed and applied in different segments.

Suitability of training models are rated against their effectiveness for employment. And standardization of training models depends on the outcomes in job market for those who were trained under a specific model.

Training models have to be peak performers in job market for securing and sustaining job satisfaction and due remunerations. Crafting a suitable model is employment and context-specific and as such it is a long-term effort.

Training models are flexible and have to change with needs of the job market and enhancement of productivity. The training models do constantly change with the changing needs of the market segment.

Training models are then not based on what the employee thinks he/she needs nor what the trainer thinks what the employee needs; training models are influenced by the job market wherein specific skills etc are required for specific employment.

Employment-specific and industry-specific needs for skill sets make the training models to be revised and re-designed as demanded by the market forces to enhance productivity.

On the job skilling is still in practice but those skills often fall short of being effective in a fast paced market. Therefore, most training models try for skills upgrading rather than deficit repair of old skills which are now obsolete.

Skills upgrading training models have better job visibility, less duration requirement and they are segment-specific and often have industry sponsors. Self-repairing training models are often least preferred. They come behind in acceptability of models that impart totally new skills.

Training models that impart totally new skills have good job visibility, flexibility, often better financing plans and faster induction to job markets.

No training model is a finished product; they are constantly modified and upgraded as per the requirements of the employers; suitable elements of the training model are retained; deficit areas are modified and improved to suit the employment needs.

Modern-day models support a potential employee with entry gate (interview) performance balancing and suitable contracts, right engagement and suitable exit strategies. They also familiarize the trainee about modern practices of remunerations linked to several point clusters of abilities manifested in skill application and productivity and performance and quality linked remunerations and rewards of peak outputs.

Most popular models are those which feature corporate needs and seamlessly managed-employee growth cycle within organizational lifecycle. ■

Modern-day models support a potential employee with entry gate (interview) performance balancing and suitable contracts, right engagement and suitable exit strategies.

(murickan@rediffmail.com)

Qualitative Research in Social Work Practice

Dr. Anupriyo Mallick

Social work has a rich history of naturalistic research. The descriptive nature of case-writings in social casework method, and worker's perceptions of client's problems in a holistic manner are very much in keeping with the principles of qualitative research. If we try to perceive general practice merely as a science, we come to the conclusion that it is not purely a biomedical science. In one situation, the focus is on bio-socio-medical aspects while in another situation, the emphasis is on psycho-social or behavioural, so the place of general practice as science lies somewhat between the bio-socio-medical and social science. Quantitative and qualitative approaches are not exclusive but complementary, answering different types of questions and providing different types of information which may be of equal importance.

What is research?

Research may be defined as a process aimed at gathering and analyzing information either for the production of new knowledge or for the recording, confirming or refuting of that what is already known or believed. A research design is the combination of procedures and methods by which a research project is conducted. Investigators have a range of research designs from which to choose. Research designs have been broadly classified into *qualitative* and *quantitative*. Both approaches are governed by two different paradigms, and both the paradigms are approaches to further develop scientific knowledge.

Qualitative research

- Observation
- Interviews
- Focus groups

Quantitative research

- Observational
- Descriptive
- Case-control
- Cross-sectional
- Cohort
- Experimental
- Clinical trials
- Quasi-experimental trials

Differences between quantitative and qualitative research

"Qualitative researchers can think but cannot count. Quantitative researchers can count but cannot think" (J Howie). A quantitative approach to research focuses on the data that can be collected, measured, subjected to statistical analysis, and numerically represented and recorded on charts and graphs. This is conventional biomedical approach to research derived from physical science.

Qualitative research on the other hand is the method of naturalistic enquiry, which is usually less obtrusive than quantitative research. In qualitative research, individual perspectives are valued as their reality. It aims to study people in their natural social settings. Qualitative research describes the words (rather than numbers) and qualities of the social phenomena through observation, interviews, and focus groups. Qualitative research examines symptoms, signs, pain, suffering, frustration, hope and beauty as seen through the eyes of the subject researched. These concepts are expressed in a descriptive way rather than a numerical way. The most important quality for the researcher in qualitative research is his creative ability – the ability to be perspective and to think abstractly.

Qualitative data

Qualitative research focuses on non-numeric organization and interpretation of data in order to discover patterns, themes, forms and qualities within the data. The data cannot be readily transformed into numbers for statistical manipulation and findings are not arrived at by means of quantification. Data are referred to as soft data through which inferences are made. Fieldwork is the cornerstone of data collection in qualitative research. It involves being with the people, making observations and talking with people, i.e. participating in their everyday life.

Methods of data collection

There are many ways of collecting data in qualitative research which include:

- Observation
- Interviews
- Focus groups

Traditional social science research that is mainly quantitative in nature is inadequate in general practice and therefore there has been an increased emphasis on qualitative research. However, quantitative and quantitative methods are not exclusive but complementary and compatible with each other.

Observation

Many classical studies have used observational methods. Here, the investigators become involved with the lives of their subjects, yet retaining their emotional detachment. They must respect the views of their subjects even if they differ from their own. They must also respect the management of the institution, often with whose permission they are able to gain access to the subjects. They should record their observations accurately. They have ethical, moral and legal responsibilities in the settings and need to be aware of these.

The researcher may play one of the several roles:

- **A complete observer**

The researcher watches from a distance and does not interact with the cases. This may prevent an adequate exploration of observation made.

- **An observer participant**

The emphasis is on the observation but the researcher does interact with the subjects, i.e. s/he talks to them and explores the issued raised and records observation.

- **A participant observer**

The researcher participates in the activities of institutions/ individuals being studied and gains the trust of the subjects to be able to question them.

Interviews

There are three main types of interviews:

- **Unstructured**

The researcher goes into the interview situation without a predetermined set of questions which the interviewer wishes to explore with his subjects. These are also termed as 'in-depth interviews'. Though unstructured interviews considerably increase the scope and richness of data, most interviews in medical researches are semi-structured.

- **Semi-structured**

These are conducted on the basis of a loose structure of open questions which define the areas to be explored. The researcher while having a standard set of questions allows the interviewee to feel free to elaborate his/her own feelings about the subject.

- **Structured**

Mostly close questions are asked in a standardized manner and are mainly used in quantitative research. An unstructured interview enhances the depth and richness of data whereas semi-structured interviews have the danger of impoverishing data by providing standard responses to the list of standard questions

Focus groups

A group session is an in-depth discussion in which a small number of people (usually 8-12) from a target population under the guidance of a facilitator (moderator) discuss the topic of study in a free and open manner. Generally, the participants are chosen purposely and it is recommended that they should be homogeneous with respect to characterization. They provide a wealth of information into motivation, attitudes, feelings and behaviour that cannot be easily obtained by quantitative methods alone.

Scope of qualitative research

Qualitative methods are particularly appropriate when researching a previously unexplained topic or one that is poorly understood or ill defined. They can address research questions of immediate relevance which are otherwise difficult to investigate. These include the process of consultation, doctor-patient relationship and understanding of patients' perspectives and similar other facets of clinical practice. Qualitative research can also enable the investigation of beliefs and attitudes on sensitive topics that would not be possible by quantitative methods.

Clearly there are situations when qualitative methods are not appropriate. They are not useful when the extent of the phenomenon is to be measured such as prevalence or incidence of a particular issue or phenomenon. They cannot be used to explore the statistical relationships between variables or to examine statistical variations between particular groups nor can they be used for statistical modelling.

There are times when it is appropriate to use qualitative and quantitative methods together in a complementary fashion. A frequent pattern is to use a qualitative study as a preliminary to quantitative study. For example: designing a questionnaire on the basis of unstructured interviews on the same topic.

Rigour in qualitative research

Qualitative research methods are often criticized because they seem to be too subjective and lack reliability and validity (rigour) which are crucial to all forms of research but are sometimes more complex to demonstrate. Good qualitative research should give answer, which are plausible, convincing and should have the power to change practice. Methods have been devised that add rigour to qualitative research and thus ensure that these studies do attain credibility in traditional quantitatively-oriented circles

How to add rigour (validity and reliability)

- Qualitative research data should be collected rigorously and systematically, preferably using more than one investigator so that check on reliability can be made.

  Meticulous records need to be kept and a separate fieldwork diary should be maintained. The categorization of data should be carried out systematically, and impressionistic material avoided in the report.
- Researcher should be honest in his/her theoretical perspective
- Research should be conducted in an explicit and systematic way in relation to design, data collection, analysis, and interpretation. The investigator must aim to reduce sources of error and bias.

Like general practice itself, its research base is broad and crosses disciplinary boundaries. Traditional social science research that is mainly quantitative in nature is inadequate in general practice and therefore there has been an increased emphasis on qualitative research. However, quantitative and quantitative methods are not exclusive but complementary and compatible with each other. Often combining of both approaches within the same research endeavour will provide a better and more complete understanding of the phenomenon under study.■

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Hospital Care for Children - 17

Start feeding when the condition of the baby is stable (usually on the second day, might be possible in more mature babies on day 1). Start feeds if there is no abdominal distension or tenderness, bowel sounds are present, meconium passed and no apnoea.

- Use a prescription chart.
- Calculate exact amounts for feeding and the timing of feeds.
- Increase on a daily basis if well tolerated.
- When commencing milk feeds, start with 2–4 ml every 1–2 hours by nasogastric tube. Some active VLBW babies can be fed with a cup and spoon or an eyedropper, which must be sterilized before each feed. Use only expressed breast milk if possible. If 2–4 ml volume is tolerated with no vomiting, abdominal distension, or gastric aspirates of more than half the feed, the volume can be increased by 1–2 ml per feed each day. Reduce or withhold feeds if signs of poor tolerance occur. Aim to have feeding established in the first 5–7 days so that the IV drip can be removed, to avoid infection.
- The feeds may be increased over the first 2 weeks of life to 150–180 ml/kg/day (three-hourly feeds of 19–23 ml for a 1kg baby and 28–34 ml for a 1.5 kg baby). As the baby grows, recalculate the feed volume based on the higher weight.

Antibiotics and sepsis

Risk factors for sepsis are: babies born outside hospital or born to unwell mothers, rupture of membranes >24 hours, smaller babies (closer to 1 kg).

Presence of any DANGER SIGNS or other signs of serious bacterial infection

- Initiate antibiotic treatment.

Apnoea

- Caffeine citrate and aminophylline prevent apnoea in premature babies. Caffeine is preferred if it is available. The loading dose of caffeine citrate is 20 mg/kg orally or IV (given slowly over 30 minutes). A maintenance dose should be prescribed
  If caffeine is not available give a loading dose of aminophylline of 10 mg/kg orally or by intravenous injection over 15–30 minutes. A maintenance dose should be prescribed.
- If an apnoea monitor is available this should be used.

Discharge and follow-up of low birth weight babies

Low birth weight babies can be discharged when:

- they have no DANGER signs or signs of serious infection
- they are gaining weight on breastfeeding alone
- they can maintain their temperature in the normal range (36–37 °C) in an open cot
- the mother is confident and able to take care.

Low birth weight babies should be given all scheduled vaccines at the time of birth, and any second doses that are due by the time of discharge.

Counselling on discharge

Counsel parents before discharge on

- exclusive breastfeeding
- keeping the baby warm
- danger signs for seeking care

Low birth weight babies should be followed up weekly for weighing, assessment of feeding, and general health until they have reached 2.5 kg.

Necrotizing enterocolitis

Necrotizing enterocolitis (NEC, a bowel infection) may occur in low birth weight babies, especially after enteral feeds are started. It is more common in low birth weight babies fed artificial formulae, but may occur in breastfed babies

Common signs of NEC are:

- Abdominal distension or tenderness
- Intolerance of feeding
- Bile-stained vomit or bile-stained fluid up the nasogastric tube
- Blood in the stools

General signs of systemic upset include

- Apnoeas

- Drowsy or unconscious
- Fever or hypothermia

Treatment

- Stop enteral feeds.
- Pass a nasogastric tube and leave it on free drainage.
- Start an IV infusion of glucose/saline
- Start antibiotics: give ampicillin (or penicillin) plus gentamicin plus metronidazole (if available) for 10 days.

If the baby has apnoea or other danger signs, give oxygen by nasal catheter. If apnoea continues give aminophylline or caffeine IV

If the baby is pale, check the haemoglobin and transfuse if Hb<10 g/dL.

Take a supine and lateral decubitus abdominal X-ray. If there is gas in the abdominal cavity outside the bowel there may be a bowel perforation. Ask a surgeon to see the baby urgently.

Examine the baby carefully each day. Reintroduce expressed breast milk feeds by nasogastric tube when the abdomen is soft and not tender, the baby is passing normal stools with no blood and is not having bilious vomiting. Start feeds slowly and increase slowly by 1–2 ml per feed each day.

Other common neonatal problems

Jaundice

More than 50% of normal newborns, and 80% of preterm infants, have some jaundice. Jaundice can be divided into abnormal or normal:

Abnormal (non physiological)

- Jaundice started on the first day of life
- Jaundice lasting longer than 14 days in term, 21 days in preterm infants
- Jaundice with fever
- Deep jaundice: palms and soles of the baby deep yellow Normal (physiological)
- Skin and eyes yellow but none of the above

Abnormal jaundice may be due to

- Serious bacterial infection
- Haemolytic disease due to blood group incompatibility or G6PD deficiency
- Congenital syphilis or other intrauterine infection
- Liver disease such as hepatitis or biliary atresia
- Hypothyroidism

Investigations for abnormal jaundice

The clinical impression of jaundice should be onfirmed by a bilirubin measurement, where possible. The investigations depend on the likely diagnosis and what tests are available, but may include:

- Haemoglobin or PCV
- Full blood count to look for signs of serious bacterial infection (high or low neutrophil count with >20% band forms), and to look for signs of haemolysis
- Blood type of baby and mother, and Coombs test
- Syphilis serology such as VDRL tests
- G6PD screen, thyroid function tests, liver ultrasound

Treatment

- Phototherapy if
- Jaundice on day 1
- Deep jaundice involving palms and soles of the feet
- Prematurity and jaundice
- Jaundice due to haemolysis

Treatment of jaundice based on serum bilirubin level

	Phototherapy				Exchange transfusion[a]			
	Healthy term baby		Preterm or any risk factors[b]		Healthy term baby		Preterm or any risk factors	
	mg/dl	µmol/l	mg/dl	µmol/l	mg/dl	µmol/l	mg/dl	µmol/l
Day1	Any visible jaundice[c]				15	260	13	220
Day 2	15	260	13	220	25	425	15	260
Day 3	18	310	16	270	30	510	20	340
Day 4 and thereafter	20	340	17	290	30	510	20	340

a *Exchange transfusion is not described in this pocket book. These serum bilirubin levels are included in case exchange transfusion is possible or in case the baby can be transferred quickly and safely to another facility where exchange transfusion can be performed.*

b *Risk factors include small size (less than 2.5 kg at birth or born before 37 weeks gestation), haemolysis, and sepsis.*

c *Visible jaundice anywhere on the body on day 1.*

Continue phototherapy until serum bilirubin level is lower than threshold range or until baby is well and there is no jaundice of palms and soles.

If the bilirubin level is very elevated *(see table)* and you can safely do exchange transfusion, consider doing so.

HEALTH BITS

When your baby falls ill

Young parents often become confused and perturbed when their child is ill," says Mumbai paediatric consultant Dr Indu Khosla. "So the sooner you learn to brief your doctor effectively, the better." A checklist to go by:

Give a clear history: Provide all details of a child's symptoms: like, 'vomiting for four days' or 'fever in the evening.'

Avoid self-medication, except for the basic drugs for fever or a mild cold, cough, or vomiting. You may also give oral rehydration salts for diarrhoea.

Keep a clinical thermometer at home

Measure and jot down your child's temperature if you feel he's feverish. Merely feeling the skin can be misleading.

Have records ready. Of previous lab tests, hospitalization, immunization, reactions, or any surgery. For newborns, keep maternal and delivery records handy.

Write down your questions

Or else you may forget to ask all you need to know, especially since kids may cry during the consultation

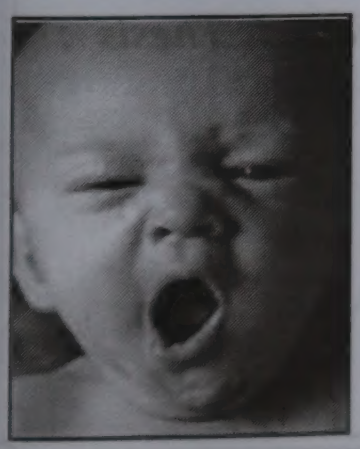
Be careful with immunization

Follow all dates given by the doctor, but if your child is sick when you take him for a shot, let the doctor know. Also tell the doctor about reactions that may have occurred after your child's earlier immunizations.

Reader's Digest, November 2007

Yawning may boost brain's alertness

Hold that yawn (if you can), and read on: a couple of psychologists of the State University of New York at Albany have concluded after a study that we yawn to boost blood flow and chill the brain. Brain-cooling explains why you can "catch' a yawn, says *New Scientist* magazine, quoting the researchers.



While reflecting on the finding, you may now y-a-w-n. Doesn't your brain feel cooler? Don't you feel more attentive?

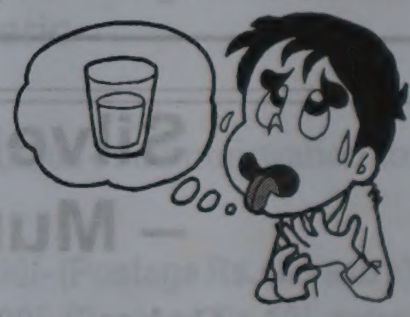
Altogether 44 college students were subjected to the study that involved, among other things, watching films of people yawning. Interestingly, subjects who held a cold pack to their forehead did not catch yawns, while those who held a warm pack yawned normally. Brains operate more efficiently when cool, they add.

As another researcher at the University of Maryland, Baltimore Country, puts it, "Yawning signals a transition between the behavioural states of wakefulness and sleepiness, and boredom to alertness.

Insight-The Consumer Magazine, September-October 2007

Diabetes or just normal thirst?

Do you feel thirsty or tired all the time? If so, you could be one of the estimated 40 million Indians who have diabetes. Here's what to look for.



- As well as increased fatigue and thirst, typical symptoms include urinating more often (as your kidneys try to excrete excess sugar), weight loss, blurred vision (caused by blood glucose accumulating in your eye's lens) and genital itching (sometimes due to infection). Cuts may also take longer to heal.
- Type 1 diabetes can be triggered by a virus and tends to develop within days or over a few weeks; type 2 onset is slower and can be mistaken for stress or ageing.
- People under 40 are more prone to Type 1 but, due to rising levels of obesity, are not the fastest growing group for Type 2 – one linked with old age. Both types run in families.
- If you're worried, go to your GP for a urine test to measure your glucose level. A healthy diet (low in salt, fat and sugar) and daily exercise are crucial for preventing Type 2.

Reader's Digest, November 2007

HEALTH BITS

Smoking turns men bald

It's no news that smoking can cause a whole array of illnesses like lung cancer, impotence and heart disease. Add a fourth to the list – baldness.

A team of international researchers has carried out a study and found that puffing on fags makes men prematurely bald as it accelerates the process of hair loss, the British media reported recently. Smoking may damage the genetic structure of the hair follicles, the tiny structures responsible for hair growth.

We have found significant associations between moderate or severe alopecia and smoking,' lead researcher Dr Lin-Hui Su said.

In fact, Dr Su of Far Eastern Memorial Hospital in Taipein and his fellow researchers came to the conclusion after analyzing the effects of smoking on a group of 700 Taiwanese men, all 40 plus.

All the men's height and weight were measured, and blood samples analyzed.

Analysis of the results showed that the risk of hair loss increased with advancing age, but remained lower than the average risk of Caucasian men.

It also revealed a clear link between smoking and hair loss, with the heaviest smokers being most likely to suffer from male pattern baldness, even when a family history of the condition was taken into account.

The researchers found that those who smoked 20 fags or more a day were more than twice as likely to have moderate or severe hair loss than those who had never smoked. The risk remained elevated even among those who had quit the habit.

The findings of the study have been published in the *Archives of Dermatology* journal.

The New Indian Express, 27 November, 2007

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involves some easy steps like selection of theme, visualization, scripting, rehearsal, demonstration etc.

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Price of CD in English : Rs.100/- (Postage Rs.60/- extra)

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